DOCUMENT RESUME

ED 330 171 EC 300 143

AUTHOR	Cross, Terry L.; And Others
TITLE	Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed.
INSTITUTION	Georgetown Univ. Child Development Center, Washington, DC. CASSP Technical Assistance Center.
SPONS AGENCY	National Inst. of Mental Health (DHHS), Rockville, MD. Child and Adolescent Service System Program.
PUB DATE	Mar 89
NOTE	90p.
AVAILABLE FROM	CASSP Technical Assistance Center, Georgetown University Child Development Center, 3800 Reservoir Rd., N.W., Washington, DC 20007 ($8.50).
PUB TYPE	Guides - Non-Classroom Use (055) -- Reports - Descriptive (141)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	Agency Role; American Indians; Asian Americans; Black Youth; *Cultural Awareness; Cultural Differences; Delivery Systems; Developmental Stages; *Emotional Disturbances; Hispanic Americans; *Mental Health Programs; *Minority Groups; Planning; Policy Formation; Program Development; Severe Disabilities
IDENTIFIERS	African Americans

ABSTRACT

This monograph provides a philosophical framework and practical ideas for improving service delivery to children of color who are severely emotionally disturbed. The monograph targets four sociocultural groups (African Americans, Asian Americans, Hispanic Americans, and Native Americans). The document emphasizes the cultural strengths inherent in all cultures and examines how the system of care can more effectively deal with cultural differences and related treatment issues. In dealing with cultural differences, there is a need to clarify policy, training, resources, practice, and research issues, and cultural competence should be viewed as a developmental process. Five elements contributing to a system's, institution's, or agency's ability to become more culturally competent are identified: value diversity, cultural self-assessment, consciousness of the dynamics of cultural interaction, institutionalization of cultural knowledge, and development of adaptations to diversity. Cultural competence must be developed at the policymaking, administrative, practitioner, and consumer levels. Service adaptations developed in response to cultural diversity may impact on intake and client identification, assessment and treatment, communication and interviewing, case management, out-of-home care, and guiding principles. Planning for cultural competence involves assessment, support building, facilitating leadership, including the minority family and community, developing resources, training and technical assistance, setting goals, and outlining action steps. (Approximately 170 references) (JDD)

ED330171

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☐ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

SCOPE OF INTEREST NOTICE
The ERIC Facility has assigned this document for processing to: EC
In our judgment, this document is also of interest to the Clearinghouses noted to the right. Indexing should reflect their special points of view. U.D

TOWARDS A CULTURALLY COMPETENT SYSTEM OF CARE

A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed

March, 1989

BEST COPY AVAILABLE

CASSP Technical Assistance Center
Georgetown University Child Development Center

EC 300 143

TOWARDS A CULTURALLY COMPETENT SYSTEM OF CARE

A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed

Prepared by:

Terry L. Cross
and
Barbara J. Bazron, Karl W. Dennis, and Mareasa R. Isaacs,

with the assistance of the Portland Research and Training Center for Improved Services to Severely Emotionally Handicapped Children and Their Families

Project Coordinator:

Marva P. Benjamin

March, 1989

This project is funded by the National Institute of Mental Health, Child and Adolescent Service System Program (CASSP)

Available from:

CASSP Technical Assistance Center
Georgetown University Child Development Center
3800 Reservoir Road, N.W.
Washington, DC 20007
(202) 687-8635

TABLE OF CONTENTS

	Page
Executive Summary	iii
Preface	ix
Chapter I: Introduction	1
Background	1
Issues	5
Policy	5
Training	6
Resources	8
Practice	9
Research	11
Chapter II: The Cultural Competence Continuum	13
Cultural Destructiveness	14
Cultural Incapacity	15
Cultural Blindness	15
Cultural Pre-competence	16
Cultural Competence	17
Cultural Proficiency	17
Chapter III: The Culturally Competent System of Care	19
Valuing Diversity	19
Cultural Self-Assessment	19
Dynamics of Difference	20
Institutionalization of Cultural Knowledge	20
Adaptation to Diversity	21
A Value Base for Cultural Competence	22
Chapter IV: Developing Cultural Competence	25
Policymaking Level	25
Administrative Level	28
Practitioner Level	32
Consumer Level	38
Chapter V: Service Adaptations	40
Intake and Client Identification	44
Assessment and Treatment	46
Communication and Interviewing	48
Case Management	50
Out-of-Home Care	51
Guiding Principles	52

Chapter VI: Planning for Cultural Competence 55

Assessing the Environment 55
Developing Support 57
Resource Development 58
Leadership Development 59
Mission and Action 60

Conclusion 62

Definitions 63

Bibliography 64

EXECUTIVE SUMMARY

This monograph, "Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed," was developed in order to assist states and communities in addressing one of the primary goals of the Child and Adolescent Service System Program (CASSP)--that of appropriateness of care. CASSP seeks to assure that system service development takes place in a culturally appropriate way in order to meet the needs of culturally and racially diverse groups. As such, this document, which is being developed in two-phases, should be particularly useful to service providers, policymakers, and administrators of public and private child-serving agencies without regard to race, culture, or ethnicity. The first phase, which is a seminal piece, was developed by a subcommittee of the Minority Initiative Resource Committee of the CASSP Technical Assistance Center at Georgetown University Child Development Center (see preface for a list of Committee members). The second phase, which focuses on program examples, is currently in the planning and design phase and will be completed at a later time.

This first phase of the monograph provides a philosophical framework and practical ideas for improving service delivery to children of color who are severely emotionally disturbed. Consistent with the focus of the CASSP Minority Initiative, this monograph targets America's four sociocultural groups of color: African Americans, Asian Americans, Hispanic Americans, and Native Americans. These groups were targeted because historically they have had limited access to economic or political power, and have, for the most part, been unable or not allowed to influence the structures that plan and administer children's mental health service systems. This monograph is not a "How To" document, and, as such, is not a compendium of specific intervention strategies or approaches. It does, however, emphasize the cultural strengths inherent in all cultures and examines how the system of care can more effectively deal with cultural differences and related treatment issues.

Recognizing the cultural complexity and rich diversity that exists among minority populations, it is felt this document should be used in conjunction with training and technical assistance, if the desired results are to be achieved. In reviewing background material for this monograph, identified issues emerged with consistent frequency. For example, there is a need to clarify policy, training, resource, practice, and research issues

as they affect the provision of mental health services to minority children/families. It is recognized, however, that neither the questions raised nor the solutions suggested in response to these issues are simple ones. Nevertheless, these issues must be addressed, especially when one considers the shift in population predicted by the year 2000. Just as the overall minority population will be increasing disproportionately, in juxtaposition to the majority population, so too will the percentage of minority clients in the service delivery system increase at a disproportionate rate. Therefore, it is projected that nearly 40 percent of the clients in the service delivery system will be minority group members by the year 2000.

In an attempt to shed some light on culturally competent systems of care for minority youth, adolescents, and their families, as conceptualized by the CASSP Minority Initiative Resource Committee, this monograph:

- provides a definition for cultural competence;
- sets forth a cultural competence continuum along a six-point continuum;
- outlines the five essential elements that contribute to a system's or agency's ability to become more culturally competent;
- identifies a set of underlying values and principles of a culturally competent system of care;
- provides some practical ideas for improving service delivery to children of color who are severely emotionally disturbed at the policymaking, administrative, practitioner, and consumer level;
- describes service adaptation as a way of delivering effective services cross-culturally; and
- outlines strategies for implementation.

The cultural competence model explored in this monograph is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. The word culture is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function effectively. A culturally competent system of care acknowledges and incorporates--at all levels--the importance of culture, the assessment of cross-cultural relations, vigilance towards the

dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs.

It is the thesis of this monograph that actions can be taken at the practitioner, agency, and system level which could greatly impact on improved services to minority children, youth, and families.

Cultural competence may be viewed as a goal toward which professionals, agencies, and systems can strive; thus, becoming culturally competent is a developmental process. One might envision responding to cultural differences by imaging a continuum that ranges from cultural destructiveness to cultural proficiency. There are at least six possibilities between these two extremes along the continuum, including:

- Cultural Destructiveness;
- Cultural Incapacity;
- Cultural Blindness;
- Cultural Pre-Competence;
- Cultural Competence; and
- Cultural Proficiency.

The culturally competent system of care is made up of culturally competent institutions, agencies, and professionals. Five essential elements contribute to a system's, institution's, or agency's ability to become more culturally competent. The culturally competent system would: 1) value diversity; 2) have the capacity for cultural self-assessment; 3) be conscious of the dynamics inherent when cultures interact; 4) have institutionalized cultural knowledge; and 5) have developed adaptations to diversity. Further, each of these five elements must function at every level of the system. Attitudes, policies, and practices must be congruent within all levels of the system. Practice must be based on accurate perceptions of behavior, policies must be impartial, and attitudes should be unbiased.

A culturally competent system of care serving children of color who are emotionally handicapped must be based on a set of underlying values and principles, such as:

- The family as defined by each culture is the primary system of support and preferred point of intervention;

- The system must recognize that minority populations have to be at least bicultural and that this status creates a unique set of mental health issues to which the system must be equipped to respond;

- Individuals and families make different choices based on cultural forces; these choices must be considered if services are to be helpful;

- Inherent in cross-cultural interactions are dynamics that must be acknowledged, adjusted to, and accepted;

- The system must sanction and in some cases mandate the incorporation of cultural knowledge into practice and policymaking;

- Cultural competence involves working in conjunction with natural, informal support and helping networks within the minority community, e.g., neighborhoods, churches, spiritual leaders, healers, etc.;

- Cultural competence extends the concept of self-determination to the community. Only when a community recognizes and owns a problem does it take responsibility for creating solutions that fit the context of the culture;

- Community control of service delivery through minority participation on boards of directors, administrative teams, and program planning and evaluation committees is essential to the development of effective services;

- An agency staffing pattern that reflects the makeup of the potential client population, adjusted for the degree of community need, helps ensure the delivery of effective services; and

- Culturally competent services incorporate the concept of equal and nondiscriminatory services, but go beyond that to include the concept of responsive services matched to the client population.

In reviewing the delivery of effective services cross-culturally, it is clear that four models frequently appear:

1) mainstream agencies providing outreach services to minorities;

2) mainstream agencies supporting services by minorities within minority communities;

3) agencies providing bilingual/bicultural services; and

4) minority agencies providing services to minority people.

Three of these four service models emphasize cultural values and helping systems: mainstream-supported minority services within minority communities, bilingual/bicultural agencies, and minority agencies providing services to minority clients.

In designing services to meet the needs of minority clients in the context of their culture, the following should be considered:

- the concept of least restrictive alternatives;
- community-based approaches with strong outreach components;
- strong interagency collaboration, including natural helpers and community systems;
- early intervention and prevention;
- intake and client identification to reduce differential treatment of minority youth;
- assessment and treatment processes that define "normal" in the context of the client's culture;
- developing adequate cross-cultural communication skills;
- the case management approach as a primary service modality; and
- the use of home-based services.

Planning for cultural competence, which assures appropriateness of care for minority populations, involves assessment, support building, facilitating leadership, including the minority family and community, developing resources, training and technical assistance, setting goals, and outlining action steps. While this process is not unique to the

development of cultural competence, it is particularly well-suited to the effort because of the scope and complexity of the issues. Such planning must be approached with the developmental nature of the acquisition of cultural competence in mind. Not all agencies will approach the issue in the same way and each will have a different timeline for development. Through the use of this or similar planning approaches, organizations can avoid feeling that the task is unmanageable and each can develop at its own pace in ways that make sense in the context of the organization.

Finally, it is felt that the theoretical knowledge base and practical ideas contained in this monograph, together with training and technical assistance, could go a long way toward improving the service delivery system for minority youth, adolescents, and their families.

PREFACE

During the past six years, much greater attention has been devoted to the needs of children and adolescents who are seriously emotionally disturbed. The seminal study by Jane Knitzer, Unclaimed Children, documented the state-level service system inadequacies across the country and sparked new efforts to examine the needs of this population. Emerging from this new momentum in 1986 was the Child and Adolescent Service System Program (CASSP) monograph, A System of Care for Severely Emotionally Disturbed Children and Youth by Stroul and Friedman, which was the first national publication to capture the spirit and concept of a "system of care" for children and adolescents who are seriously emotionally disturbed. The monograph to follow herein enhances the work of Stroul and Friedman by focusing on services for minority children and families and presents a "culturally competent" system of care.

This monograph was made possible through the commitment, dedication, hard work, and expertise of a multidisciplinary group of professionals who are minority group members. These professionals, who are also members of the CASSP Minority Initiative Resource Committee, are experienced in program, policy, and administration involving children and adolescents with special needs from culturally and racially diverse backgrounds.

A subcommittee, chaired by Terry L. Cross and including Barbara J. Bazron, Karl W. Dennis, and Mareasa R. Isaacs, with the assistance of the Portland Research and Training Center for Improved Services to Severely Emotionally Handicapped Children and Their Families, took major responsibility for conceptualizing and preparing the monograph.

The unique approach to developing this monograph involved the combined thinking, collaborative efforts, and consensus-building strategies of the Minority Initiative Resource Committee. This effort commenced in May, 1988 at the first CASSP Minority Initiative Resource Committee Meeting, which was held in Washington, D.C. Although CASSP efforts to improve services to minority youth pre-dated the establishment of a formal Minority Initiative Resource Committee structure, it was a Resource Committee recommendation that subsequently led to the development of this monograph. Special thanks go out to Terry L. Cross, other members of the subcommittee, and members of the CASSP Minority Initiative Resource Committee for their unselfish contributions in making this monograph possible. Although not all of the members were present at the initial May

meeting, the CASSP Minority Initiative Resource Committee currently consists of the following members:

William Arroyo, M.D., Assistant Clinical Director, Child and Adolescent Outpatient Unit, University of Southern California, Los Angeles, CA

Barbara J. Bazron, Ph.D., Executive Director, Pittsburgh New Futures, Pittsburgh, PA

Lemuel B. Clark, M.D., Associate Director, Division of Education and Service Systems Liaison, National Institute of Mental Health, Rockville, MD

Anita Chisholm, Director, American Indian Institute, Norman, OK

Terry L. Cross, A.C.S.W., Director, Northwest Indian Child Welfare Institute, Portland, OR

Karl W. Dennis, Executive Director, Kaleidoscope, Inc., Chicago, IL

Carl J. Donaldson, Jr., CASSP Project Planner, Division of Mental Health and Hospitals, Bureau of Children's Services, Princeton, NJ

Jerome H. Hanley, Ph.D., Director, Division of Child and Adolescent Services, Department of Mental Health, Columbia, SC

Mareasa R. Isaacs, Ph.D., Administrator, Child/Youth Services Administration, Commission on Mental Health Services, Washington, DC

May Kwan Lorenzo, Ph.D., Clinical Social Worker, South Cove Community Health Center, Boston, MA

Brenda W. Lyles, Ph.D., Director, Quality Assurance Monitoring Group, QAM Group, New Orleans, LA

Bernie H. Manning, Ph.D., Chief, Division of Policy, Planning, and Auditing, Bureau of Special Education, Pennsylvania Department of Education, Harrisburg, PA

Maxwell Manning, A.C.S.W., CASSP Project Manager, Brooklyn Children and Family Services Network, Brooklyn, NY

James L. Mason, Project Manager, Minority Cultural Initiative, Research and Training Center to Improve Services to Emotionally Handicapped Children and Families, Portland State University, Portland, OR

Denise Rosario, A.C.S.W., CASSP Project Associate, Brooklyn Children and Family Services Network, Brooklyn, NY

Jose Soto, J.D., CASSP Manager, Department of Public Institutions, Office of Community Mental Health, Lincoln, NE

Kenley R. Wade, M.M., Administrator, Bureau of Child and Adolescent Services, CASSP Project Director, Department of Mental Health and Developmental Disabilities, Springfield, IL

Nancy Ware, Interagency Coordinator, Child/Youth Services Administration, Commission on Mental Health Services, Washington, DC

It is felt that the theoretical knowledge base and practical ideas contained in this monograph, together with training and technical assistance, could go a long way toward improving the service system for minority youth and adolescents who are seriously emotionally disturbed and for their families. Because of the complex nature of human behavior, the tremendous and rich diversity which exists among the various subgroups of minority populations in the country, and the important role which culture plays in the lives of all human beings, the subcommittee set out to develop a philosophical framework that would promote the understanding that people think differently and make different choices based upon cultural traditions and experiences. However, extreme caution must be taken to avoid the dangers of stereotyping any group of people. The examples used in this monograph (while enlightening) do not necessarily apply to all members of a specific subgroup, but rather are offered as a way of better understanding the

behavior/perspective/life view of individuals who share similar backgrounds and who, for the most part, have experienced discrimination and poverty.

This monograph, just as the CASSP Minority Initiative which provided the impetus for its development, focuses on America's four sociocultural groups of color: African Americans, Asian Americans, Hispanic Americans, and Native Americans. However, it should be stressed that there are individual, group, and regional differences that people of color may choose to utilize in identifying themselves. Nevertheless, for purposes of communication, in making references to the four sociocultural groups of color identified in this monograph, the committee made no attempt to distinguish between Latinos and Hispanic Americans, Blacks and African Americans, Native Americans and American Indians, or to identify Asian Americans with any degree of specificity. Rather, identified terms are used interchangeably. Likewise the terms "severely emotionally disturbed" and "severely emotionally handicapped" are also used interchangeably.

Although the first phase of this two-phase monograph encompasses an overall philosophy, principles for a minority focused system of care, and a culturally competent continuum of care focused on children and adolescents who are seriously emotionally disturbed, it is felt that the principles identified could apply to any setting, program, agency, or individual providing services to minority group members. This monograph does not provide clinical solutions, nor is it meant to identify specific intervention strategies, techniques, or approaches. It is not a "How To Manual," but it does lay a foundation for further development. The second phase of the monograph, which will highlight program examples, is currently in the planning stages and will be completed sometime in 1990.

Marva P. Benjamin, A.C.S.W.
Director
Minority Initiative
CASSP Technical Assistance Center
Georgetown University Child Development
Center

CHAPTER I: INTRODUCTION

(Portions of this chapter have been reprinted from *Focal Point*, Vol. 3, #1, Summer, 1988 issue).

BACKGROUND

One of the primary goals of the Child and Adolescent Service System Program (CASSP) has been to deliver culturally relevant services to minority children and youth with serious emotional handicaps and their families. This goal recognizes that our country is made up of racial, cultural, and religious minorities, and further, that children's mental health is steeped in many of the same racial and cultural biases and prejudices that affect our nation's other institutions. This goal also acknowledges that insufficient attention has been paid to understanding the culture-specific characteristics of racial and ethnic minority groups as a means of identifying mental health needs and planning mental health services (Dawkins, M., Dawkins, M.P., and Terry, 1979).

This monograph is designed to provide a philosophical framework and practical ideas for improving service delivery to children of color who are seriously emotionally handicapped. It proposes a way of thinking about race and culture that is equally relevant for both the minority agency and the mainstream non-minority agency. The ideas and suggestions throughout this document are intended to facilitate the development of culturally competent services. It addresses why culture is important and how the system of care can be refined to better meet the needs of all children. The monograph briefly reviews the problems minority children face in the system and relevant literature. It discusses a model called cultural competence, and outlines paths to becoming culturally competent. This document is intended for service providers, policymakers, and administrators of public and private child-serving agencies without regard to race, culture, or ethnicity. It is for anyone who is in a position to improve services for minority children with emotional handicaps.

The term "minority" in itself can be confusing. In a global context, non-Caucasian people constitute a majority of the world's population and not a minority. Thus, the term can rob many American minorities of a sense of cultural heritage and achievement, as well as potential sources of emotional or spiritual strength and human dignity. The term was originally used to refer to Blacks and other people of color who were victims of overt racial discrimination in this country. However, as Jenkins (1981) notes: "The term has been

broadened to include a variety of groups who have been disadvantaged in one way or another who all receive the minority designation to the consternation of other groups who feel hard-won gains achieved through civil rights legislation being eroded and diffused."

Irish, Jewish, Italian, and Polish are among America's many ethnic groups; yet, they also belong to the dominant population and are not considered minority groups in contemporary parlance. Therefore, the criteria for minority status should include groups that are both powerless and relatively few in number (Jenkins, 1981). Such groups are characterized by the absence of power as opposed to the misuse of power which makes the minority group subject to the values and goals of the dominant group (Solomon, 1976).

The CASSP Minority Initiative focuses upon America's four sociocultural groups of color: African Americans, Asian Americans, Hispanic Americans, and Native Americans. These groups were targeted because historically they have had limited access to economic or political power and have been unable or not allowed to influence the structures that plan and administer children's mental health service systems.

Efforts to improve services to minority children and youth with serious emotional handicaps and their families is tied to one's ability to understand and empower minority families and communities. In order to work productively with racial and cultural communities, partnership must replace paternalism (Kurtz and Powell, 1987; Solomon, P., 1987; Hammerschlag, 1982; Ellsworth, Hooyman, Ruff, Stam, and Tucker, 1980). This notion embodies the concept that minority people and communities must be enabled to determine their own destinies. Many earlier attempts to plan services and make policy for minority communities have been rooted in a push toward assimilation typically based on a pathology model rather than on cultural pluralism. In the sixties, for example, the major barriers to racial integration were viewed as based on the sociocultural characteristics of Blacks themselves rather than on the dominant society's own racism (Metzger, 1971; Guthrie, 1976). Gary (1983) admonishes against using what are essentially pathology models to understand cultural dynamics and environmental strengths of Black people and communities.

Because of the history and survival skills inherent in minority communities, there may be some understandable resistance on the part of some communities as the path to improved services is embarked upon. However, within the CASSP extended family considerable wisdom and expertise exists that can facilitate one's ability to work with the various

minority communities. There must be commitment to and understanding of why this goal is important. Perhaps the distinguishing feature of empowering people is respect and faith in the capacity of a specific constituency to help themselves. When empowered, minority communities are up to the challenge. The challenge to professionals is to develop the understanding and commitment necessary to embark on such an ambitious journey.

This monograph is designed to offer a new perspective--a perspective that emphasizes the strengths inherent in all cultures and examines how the system of care can more effectively deal with cultural differences and related treatment issues. It is felt that culture is an untapped resource for many of these children, and it is hoped the time will come when children and families can feel enriched by their culture and throw off the message that it is only one more handicap.

Here the model called "cultural competence" is explored. It involves systems, agencies, and practitioners with the capacity to respond to the unique needs of populations whose cultures are different than that which might be called "dominant" or "mainstream" American. The word culture is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function in a particular way: the capacity to function within the context of culturally-integrated patterns of human behavior as defined by the group. While this publication focuses on ethnic minorities of color, the terminology and the thinking behind this model applies to each person--everyone has or is part of a culture.

From the system level to agencies to the practitioner it is necessary to begin to clearly and specifically state what one would be doing if, in fact, one were meeting the needs of minority children who are seriously emotionally disturbed. In the last ten years, the field has progressed in cross-cultural practice theory, but in the area of agency planning and system change there is a long way to go.

This monograph is an attempt to bring together the thinking of many people to focus on concrete actions that can be undertaken to better meet the needs of minority children. Before exploring the cultural competence model, some of the problems and issues affecting children of color in the current system of care will be outlined.

If you are an adolescent and Black and you are seriously emotionally disturbed, chances are you will end up in the juvenile justice system rather than in the treatment setting to which your Caucasian counterpart would be referred (Comer and Hill, 1985; Hawkins and Salisbury, 1983). If you are a Native American child and seriously emotionally disturbed, you will likely go without treatment or be removed legally and geographically from your family and tribe (Berlin, 1983; Shore, 1978). If you are a child who is Hispanic and seriously emotionally disturbed, you will likely be assessed in a language not your own (Padilla, Ruiz, and Alvarez, 1975). And if you are an Asian child and seriously emotionally disturbed, you will likely never come to the attention of the mental health system (Chin, 1983). In short, if you are a racial minority of color, you will probably not get your needs met in the present system. Yet, you are more likely to be diagnosed seriously emotionally disturbed than your Caucasian counterpart. When you do make it into the system, you will experience more restrictive interventions. Cultural traits, behaviors, and beliefs will likely be interpreted as dysfunctions to be overcome. The data are clear: the system of care provides differential treatment to minority children in various service systems (Cummins, 1986; Dana, 1984; Katz-Leavy, Lourie, and Kaufman, 1987; Ortiz and Maldonado-Colon, 1986; Stehno, 1982).

In a review of available data, Stehno (1982) related a variety of troubling findings concerning differential treatment for minority children. Five patterns are reported by Stehno: (1) higher rates of out-of-home placement among minority children than among Caucasian children; (2) different, more restrictive patterns of referral and diagnosis for Black youth than for Caucasian youth; (3) disproportionate numbers of Black children in less desirable placements; (4) greater proportions of Black children served in the public sector than in the private sector; and (5) less social service support received by minority parents than by non-minority parents. National Institute of Mental Health data showed that Black youth were more likely than Caucasian youth to enter the mental health system with a diagnosis of schizophrenia and character disorder and less likely than Caucasian youth to receive a diagnosis of depression or adjustment reaction (Stehno, 1982). Over recent years, it has become increasingly clear that the system of care cannot afford to neglect the mental health needs of minority children and adolescents.

The makeup of our nation is rapidly changing. By the year 2000, those now called minorities will outnumber what is now the majority in some states. It is estimated that people of color will make up 40 percent of the population in the service delivery system. Population statistics indicate that non-Caucasian groups are younger and have more rapidly

growing birth rates than the majority society (McAdoo, 1982). Should these trends continue, the challenges that face this nation in producing a system of care for children with emotional handicaps will increase rapidly as well (Lum, 1986). The opportunity currently exists to plan and adapt, in a thoughtful, culturally-sensitive way, a culturally competent system of care toward the goal of improving services to minority youth. To guide this development, the issues that affect provision of mental health services to minority children must be understood.

ISSUES

This section presents a brief review of some of the issues that affect the provision of mental health services to minority children. It must be stated, however, that there is a lack of knowledge in this area. Consequently, this document is seen as a beginning step in the process of clarifying issues affecting mental health service delivery for minority children. Such issues as a minority-focused definition of family and community and the jurisdiction each has vis-a-vis the minority child need to be explored further. This discussion has been arranged under five major headings: policy, training, resources, practice, and research.

Policy

Numerous policy issues affect service delivery to children who are emotionally handicapped and of minority cultures. First and foremost, most states have not had a specific focus in the area of services to children of color. Many do not even record the number of minority children who receive services nor have they considered it important to do so. Few states include minority representation on policymaking boards and commissions, and few minorities have been in key policymaking positions or management positions. Few states have addressed the issue of differential service delivery. While it has been clear for some time that minority children enter the service system at a different point than do dominant culture children, few, if any, policies have addressed the issue. Some policymakers have not known what to do nor have they had the resources to experiment with demonstration projects. The widespread out-of-home placement for minority children in non-minority homes continues to be a problem. For example, despite the Indian Child Welfare Act, Indian children continue to be placed in out-of-home care at high rates. Transracial placement has become a major mental health issue for minority children who suffer from difficulties with identity formation, inadequate coping skills, and loss of support systems (Shore, 1978; Berlin, 1978).

Another policy area that remains a problem for some minority children is that of jurisdiction. Indian children with emotional disabilities, for example, often remain in limbo without treatment because the Indian Health Service (IHS), the Bureau of Indian Affairs (BIA), and states, counties, and tribes cannot determine who is responsible for the cost of care (Cross, 1986b).

Some states and counties are increasingly reliant on contracted services to provide mental health services to children with emotional disorders. Minority children have consistently been under-represented in private agencies and hospitals whose services are designed to meet the needs of the dominant society (Barrera, 1978; Gallegos, 1982; Gary 1987a; Meinhardt and Vega, 1987). Little has been done in the area of contracting to assure that the private sector is equipped to effectively serve the minority child.

In some communities, minority-operated programs have developed. However, a debate has arisen over whether separate services should be encouraged or whether existing mainstream agencies should become more accessible to minority clients. In fact, both approaches contribute to the continued improvement of services to minority children. The minority agency is advisable in communities with sufficient numbers to support such an effort. It tends to add to the knowledge base for minority practice and is often able to provide services more effectively. It also results in higher utilization rates and satisfaction rates for minority clients (Flaskerud, 1986a, 1986b; Lee, 1979; Lorenzo and Adler, 1984). However, in most areas, minority children will inevitably be served in the mainstream agency. This is especially true when the shift in population predicted by the year 2000 is considered. As stated earlier, it is projected that nearly 40 percent of the clients in the service delivery system will come from the minority population by the year 2000.

Training

The training of mental health professionals has been problematic in at least two ways. There is a shortage of trained minority persons to work in the field (Gallegos, 1982; Hopps, 1987; Korchin, 1980; Sanders, 1974), and the existing curricula for mental health providers inadequately addresses the needs of minority communities (Lum, 1986). The latter deficit is in part related to the lack of a knowledge base in working cross-culturally. Until about ten years ago there was little relevant literature to guide practice and even less in the policy area. While the literature has expanded greatly in the past decade, it has not been

widely disseminated nor embraced by mental health educators. Cross-cultural practice has not been institutionalized in most professional schools to the extent necessary for professionals to serve minority clients adequately (Green, 1982; Hopps, 1988; Kumabe, Nishida and Hepworth, 1985; LaFromboise and Plake, 1984; LaFromboise, 1988). Where progress has been made, content has focused on the development of cultural knowledge about specific groups rather than on understanding culture and its function in human behavior. The field lacks standards to guide education in this area, because it has yet to define what one should know to be competent in serving minority clients. In addition, the system lacks incentives for the development of cross-cultural skills. Many mental health professionals are in private practice where the clientele is largely non-minority and economic rewards are greater. Without requirements for cultural competence built into licensing standards, it is unlikely that most professionals will be responsive to calls for cultural competence training.

Both higher education and in-service training programs have, until recently, tended to focus on the individual rather than the family. Most theories have minimized the importance of culture (Draguns in Marsella and Pederson, 1981). Information about children has been lacking, and, in particular, there has been insufficient investigation into cultural variables in growth, development, and bonding.

Lack of a knowledge base has also restricted the development of minority professionals. Schools training mental health professionals have failed to consult the minority community about needed curricula and have failed to create learning environments congruent with minority learning needs. The educational system for mental health providers has too often focused on upper-level degrees and not developed a continuum of service providers ranging from paraprofessional to professional. Few programs have focused on the training or support of natural helpers.

When minority persons have successfully completed training, they sometimes find that the education offered by the non-minority institution serves to alienate them from their community rather than make them a resource (Basu, R., Basu, A., and Kesselman, 1978; LaFromboise and Plake, 1984; Munoz, 1981). Most minority professionals have not been trained in the cultural needs of their own people. Formal education all too often further assimilates the professional into the dominant society's value system, separating them from the very resources that are the greatest assets of their community. The minority professional soon learns that to become a credentialed professional makes one suspect in

the eyes of one's own people. This is further complicated by the fact that the educational opportunities are seldom within one's own community and the reality that mental health services are often viewed as a threat rather than a source of help. Lack of appropriate content, restricted access, culturally unresponsive learning environments, and lack of community input into the process keep the number of minority service providers at a minimum. Inadequate in-service training tends to keep those minorities in the profession, alienated from their community.

Resources

Securing adequate resources for children's services in general is problematical. However, for minority populations the problem is even more acute. A number of resource issues affect service delivery to minority children. The most significant service delivery issue is accessibility (Owan, 1982; Flaskerud, 1986b). Mental health services for minority children are inaccessible in a variety of ways. Minority communities may be isolated geographically from services, or access may be restricted by language (Barrera, 1978; Rueda, 1984), distrust (Brown, E.F., 1977; Jones, D.M., 1978; Polk, 1987), or cultural differences. For instance, it is difficult for the members of some groups to seek services when their perception may be that the mental health system is an extension of the hostile state interested in scrutinizing the clients rather than in helping them. Some minority persons avoid services where they do not see people who look like themselves (Sue, D.W., 1981). For some minorities, particularly Asians and Hispanics, this issue is further aggravated by the lack of linguistic understanding. They have come to expect the non-minority worker to be unable to relate to their needs or to even be a threat to their families. Whether access is restricted by physical/language barriers or emotional/cultural ones, minority children do not have access to the same level of services enjoyed by the rest of society.

Minority operated and controlled programs/agencies have developed to deal with this lack of access issue. However, their struggle for survival has been intense. Such programs/agencies acutely feel the need for more trained minority professionals. These programs/agencies are often started as demonstration projects and then find it difficult to obtain stable funding streams to support their operating budget. They are seldom the beneficiaries of the private sector or government agencies in the same way as are mainstream, established non-minority agencies. Minority-controlled programs/agencies continually struggle for survival. With scarce resources it is difficult for such

programs/agencies to develop culturally-specialized approaches or materials for use with their clients. Consequently, they remain underdeveloped.

Both minority and non-minority agencies lack such resources as culturally-specific parent training curricula, community education tools, and prevention videos. Although some material of this type has been developed, better dissemination efforts are essential. Further, both types of agencies often lack the technology that would help them tap into the vast resources of such informal helping networks as the family, community, church, or natural helpers. There is a need to develop new practice theories and approaches for minority communities (Isaacs, 1986).

Practice

The use of formal mental health services for the treatment of children is a relatively new development, especially for children of color. However, support and help for children with emotional problems is as old as culture itself. Cultures around the world have historically had natural helping systems which were designed to ensure their future. Culturally-defined ways to nurture and protect children have included beliefs and practices that contributed to the development of good mental health. Through dream interpretation, herbal remedies, purification customs, and other ways, various peoples were able to maintain mental health. By employing these and other practices, each culture maintained an informal system of mental health care (Prince, 1980; Pedersen, Lorner, and Draguns, 1976). By avoiding imbalances, which today would be defined as emotional disturbances or mental illness, some cultures were able to prevent serious problems before they occurred. Today, various cultures still have informal systems. These informal systems exist along side formal systems.

However, the nature of these natural systems has been seldom understood or valued by the formal mental health system in existence today. The reality today is that for many there is a parallel system of care that is based in culture and community (McRoy, Shorkey, and Garcia, 1985). To be successful in providing mental health services to minority communities, it will be necessary to understand and work with this alternative system.

Some of the practice issues are cross-cultural issues, while others are applicable regardless of the service provider's identity. Cross-cultural issues include such things as historic distrust (Lockart, 1981), language and communication barriers (Barrera, 1978;

Carrasquillo, 1986; Dew, 1984; Freed, 1988), and culturally-biased assessment techniques such as interviewing and testing (Cummins, 1986; Dana, R.H., 1984; Dana, R.H., Hornby, and Hoffman, 1984; Lefley and Bestman, 1984). Also, value conflicts often bias evaluators negatively. For example, minority individuals are viewed negatively when they do not exhibit the traits valued by mainstream Americans such as punctuality, work, achievement, and independence (Lewis and Ho, 1975). Other factors that influence practices are the images and stereotypes non-minority people hold of minority people (Lum, 1986). The media, textbooks, and pop culture have unfortunately conditioned many people to have negative impressions of minority cultures. Some helpers have unrealistic fears of their minority clients and stereotypic ideas of their lives (Chin, 1983). Even when mental health professionals learn about a culture there is a tendency to simply replace old stereotypes with new ones and assume that all members of a particular minority subgroup engage in a pattern or activity and interact in a certain way. Moreover, Asians and Hispanics are confronted with an "homogenizing" attitude repeatedly, even though they have vast differences in cultural, historical, and political backgrounds, i.e., Japanese vs. Korean; Cambodian vs. Vietnamese, etc. Most practitioners have not had the opportunity to learn about the dynamics inherent in working cross-culturally and thus fail to establish rapport with their minority clients.

Practice issues include mental health issues specific to minority populations, such as working with extended families. Child development in the context of the extended family is poorly understood (Attneave, 1969; Keefe, Padilla, and Carlos, 1979; Kenyatta, 1980). The pressures and stresses of assimilation and living in a world hostile to one's culture need to be evaluated for their impact on children's mental health (Campfens, 1981; Coyle, 1984). These pressures and stresses are further compounded for the new immigrant minority populations, who not only are confronted with cultural "shock," but, in many instances, lack the language skills and knowledge to communicate effectively. The impact of pervasive out-of-home placements on minority children is not clear. Few practice models consider racial identity formations (Sue, D.W., 1981). Similarly, there are few culturally-specific approaches to alcoholism and suicide (Berlin, 1983; Chin, 1983; Comer and Hill, 1985).

Research

One problem that contributes to the state of services for minority children is the lack of research. A wide variety of subject areas need attention, including: the frequency and character of emotional disturbances, etiology, evaluation of treatment approaches, influence of cultural bias in testing, and the impact of bicultural existence on mental health. Such research is difficult to conduct, given the current capacity of the system to generate data. In 1982, over half of the children in the child welfare system, for example, could not be traced by race (Stehno, 1982). Little is known about the number of minority children with emotional disorders or the kinds of services they receive. Not enough is currently known about the range of programs offered and their effectiveness (Knitzer, 1982). Current research too often fails to consider culture as a variable. Research program funding sources historically have not been sensitive to minority needs and thus do not follow direction from minority communities. Classification of groups as "other" in research findings is one example of this insensitivity.

Just as important as the lack of adequate research is the unfortunate manner in which research has been conducted in the past. Too often research has been conducted without the consent, consultation, or participation of the subject population and the resulting information has not found its way back into the community (Brown, E.F., 1977; Hendricks, 1987; Manson and Shore, 1981; Ryan, 1980). Researchers have historically taken from the minority community and returned little. Horror stories in some communities, such as the syphilis studies in which Black men went untreated for syphilis without their knowledge or consent, have left a distrust in many communities for research (Jones, J.H., 1981). Numerous authors have cited the use of overgeneralization from research findings as a source of stereotyping (Bloombaum, Yamamoto, and Evans, 1968; Herzog, 1970; Moore, 1973; English, 1974). New methods of research that involve the community--from planning to dissemination--need to be developed and implemented.

Why is there such a differential between how minority children and mainstream children are treated in the system? How can the system respond to the changing demographics of a nation and a service population? What can be done as corrective measures? Who can best respond to these needs? These and other questions have been a matter of serious debate in recent years as mental health professionals have struggled with how to make the system more responsive to the needs of minority children and their families. Neither the questions

nor the solutions are simple, and, while advocates from minority communities clamor for culturally sensitive services, the professional world has had very little notion of what that means. The remainder of this document examines where the system of care stands and what it might be doing in response to these issues.

CHAPTER II: THE CULTURAL COMPETENCE CONTINUUM

(Substantial portions of this chapter have been reprinted from *Focal Point*, vol. 3, #1, Fall, 1988 issue).

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations. The word "culture" is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function effectively. A culturally competent system of care acknowledges and incorporates--at all levels--the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs.

Certainly this description of cultural competence seems idealistic. How can a system accomplish all of these things? How can it achieve this set of behaviors, attitudes, and policies? Cultural competence may be viewed as a goal towards which agencies can strive. Accordingly, becoming culturally competent is a developmental process. No matter how proficient an agency may become, there will always be room for growth. It is a process in which the system of care can measure its progress according to the agency's achievement of specific developmental tasks. As the tasks are defined, the system will be guided toward progressively more culturally competent services. First, it is important for an agency to internally assess its level of cultural competence.

To better understand where one is in the process of becoming more culturally competent, it is useful to think of the possible ways of responding to cultural differences. Imagine a continuum that ranges from cultural destructiveness to cultural proficiency. There are a variety of possibilities between these two extremes. The six points along the continuum and the characteristics that might be exhibited at each position are as follows:

Cultural Destructiveness

The most negative end of the continuum is represented by attitudes, policies, and practices that are destructive to cultures and consequently to the individuals within the culture. The most extreme examples of this orientation are programs/agencies/institutions that actively participate in cultural genocide--the purposeful destruction of a culture. For example, the Exclusion Laws of 1885-1965 (Hune, 1977) prohibited Asians from bringing spouses to this country, immigration quotas restricted their migration, and laws denied basic human rights on the state and federal level. Another example of cultural genocide is the systematically attempted destruction of Native American culture by the very services set up to "help" Indians, i.e., boarding schools (Wilkinson, 1980). Equally destructive is the process of dehumanizing or subhumanizing minority clients. Historically, some agencies have been actively involved in services that have denied people of color access to their natural helpers or healers, removed children of color from their families on the basis of race, or purposely risked the well-being of minority individuals in social or medical experiments without their knowledge or consent.

One area peculiar to Native Americans is the Indian Child Welfare Act. This act is an example of a legislative response to culturally-destructive practices. The Act sets up requirements for states regarding placement procedures for Indian children. These requirements are designed to protect children's rights to their heritage and to protect children as the most valuable resource of Indian people. States must deal with Indian tribes on a government-to-government basis.

While not many examples of cultural destructiveness are currently seen in the mental health system, it provides a reference point for understanding the various possible responses to minority communities. A system which adheres to this extreme assumes that one race is superior and should eradicate "lesser" cultures because of their perceived subhuman position. Bigotry coupled with vast power differentials allows the dominant group to disenfranchise, control, exploit, or systematically destroy the minority population.

Cultural Incapacity

The next position on the continuum is one at which the system or agencies do not intentionally seek to be culturally destructive but rather lack the capacity to help minority clients or communities. The system remains extremely biased, believes in the racial superiority of the dominant group, and assumes a paternal posture towards "lesser" races. These agencies may disproportionately apply resources, discriminate against people of color on the basis of whether they "know their place," and believe in the supremacy of dominant culture helpers. Such agencies may support segregation as a desirable policy. They may act as agents of oppression by enforcing racist policies and maintaining stereotypes. Such agencies are often characterized by ignorance and an unrealistic fear of people of color. The characteristics of cultural incapacity include: discriminatory hiring practices, subtle messages to people of color that they are not valued or welcome, and generally lower expectations of minority clients.

Cultural Blindness

At the midpoint on the continuum, the system and its agencies provide services with the express philosophy of being unbiased. They function with the belief that color or culture make no difference and that all people are the same. Culturally-blind agencies are characterized by the belief that helping approaches traditionally used by the dominant culture are universally applicable; if the system worked as it should, all people--regardless of race or culture--would be served with equal effectiveness. This view reflects a well-intended liberal philosophy; however, the consequences of such a belief are to make services so ethnocentric as to render them virtually useless to all but the most assimilated people of color.

Such services ignore cultural strengths, encourage assimilation, and blame the victim for their problems. Members of minority communities are viewed from the cultural deprivation model which asserts that problems are the result of inadequate cultural resources. Outcome is usually measured by how closely the client approximates a middle class, non-minority existence. Institutional racism restricts minority access to professional training, staff positions, and services.

Eligibility for services is often ethnocentric. For example, foster care licensing standards in many states restrict licensure of extended family systems occupying one home. These agencies may participate in special projects with minority populations when monies are specifically available or with the intent of "rescuing" people of color. Unfortunately, such minority projects are often conducted without community guidance and are the first casualties when funds run short. These agencies occasionally hire minority staff, but tend to be motivated more by their own needs than by an understanding of the needs of the client population. Such hiring drains valuable resources from the minority community.

Culturally-blind agencies suffer from a deficit of information and often lack the avenues through which they can obtain needed information. While these agencies often view themselves as unbiased and responsive to minority needs, their ethnocentrism is reflected in attitude, policy, and practice.

Cultural Pre-Competence

As agencies move toward the positive end of the scale they reach a position called cultural pre-competence. This term was chosen because it implies movement. The pre-competent agency realizes its weaknesses in serving minorities and attempts to improve some aspect of their services to a specific population. Such agencies try experiments, hire minority staff, explore how to reach people of color in their service area, initiate training for their workers on cultural sensitivity, enter into needs assessments concerning minority communities, and recruit minority individuals for their boards of directors or advisory committees. Pre-competent agencies are characterized by the desire to deliver quality services and a commitment to civil rights. They respond to minority communities' cry for improved services by asking, "What can we do?" One danger at this level is a false sense of accomplishment or of failure that prevents the agency from moving forward along the continuum. An agency may believe that the accomplishment of one goal or activity fulfills their obligation to minority communities or they may undertake an activity that fails and are therefore reluctant to try again.

Another danger is tokenism. Agencies sometimes hire one or more (usually assimilated) minority workers and feel they are then equipped to meet the need. While hiring minority staff is very important, it is no guarantee that services, access, or sensitivity will be improved. Because minority professionals are trained in the dominant society's frame of reference, they may only be a little more competent in cross-cultural practice than their co-

workers. Minority professionals, like all other professionals, need training on the function of culture and its impact on client populations. The pre-competent agency, however, has begun the process of becoming culturally competent and often only lacks information on what is possible and how to proceed.

Cultural Competence

Culturally competent agencies are characterized by acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations to service models in order to better meet the needs of minority populations. Such agencies view minority groups as distinctly different from one another and as having numerous subgroups, each with important cultural characteristics. Culturally competent agencies work to hire unbiased employees, seek advice and consultation from the minority community, and actively decide what they are and are not capable of providing to minority clients. Culturally competent agencies seek minority staff whose self-analysis of their role has left them committed to their community and capable of negotiating a bicultural world. These agencies provide support for staff to become comfortable working in cross-cultural situations. Further, culturally competent agencies understand the interplay between policy and practice, and are committed to policies that enhance services to diverse clientele.

Cultural Proficiency

The most positive end of the scale is advanced cultural competence or proficiency. This point on the continuum is characterized by holding culture in high esteem. Culturally proficient agencies seek to add to the knowledge base of culturally competent practice by conducting research, developing new therapeutic approaches based on culture, and publishing and disseminating the results of demonstration projects. Culturally proficient agencies hire staff who are specialists in culturally competent practice. Such agencies advocate for cultural competence throughout the system and for improved relations between cultures throughout society.

In conclusion, the degree of cultural competence agencies achieve is not dependent on any one factor. Attitudes, policies, and practices are three major arenas wherein development can and must occur if agencies are to move toward cultural competence. Attitudes change to become less ethnocentric and biased. Policies change to become more flexible and

culturally impartial. Practices become more congruent with the culture of the client from initial contact through termination. Positive movement along the continuum results from an aggregate of factors at various levels of an agency's structure. Every level of an agency (board members, policymakers, administrators, practitioners, and consumers) can and must participate in the process. At each level the principles of valuing difference, self-assessment, understanding dynamics, building cultural knowledge, and practice adaptations can be applied. When, at each level, progress is made in implementing the principles, and as attitudes, policies, and practices change in the desired direction, an agency becomes more culturally competent.

CHAPTER III: THE CULTURALLY COMPETENT SYSTEM OF CARE

(Portions of this chapter have been adapted from *Focal Point*, vol. 2, #4, Summer, 1988 issue).

The culturally competent system of care is made up of culturally competent institutions, agencies, and professionals. Five essential elements contribute to a system's, institution's, or agency's ability to become more culturally competent. The culturally competent system values diversity, has the capacity for cultural self-assessment, is conscious of the dynamics inherent when cultures interact, has institutionalized cultural knowledge, and has developed adaptations to diversity. Further, each of these five elements must function at every level of the system. Attitudes, policies, and practices must be congruent within all levels of the system. Practice must be based on accurate perceptions of behavior, policies must be impartial, and attitudes should be unbiased. As mentioned earlier, unbiased does not mean color blind; rather it means acceptance of the difference of another.

VALUING DIVERSITY

To value diversity is to see and respect its worth. A system of care is strengthened when it accepts that the people it serves are from very different backgrounds and will make different choices based on culture. While all people share common basic needs, there are vast differences in how people of various cultures go about meeting those needs. These differences are as important as the similarities. Acceptance of the fact that each culture finds some behaviors, interactions, or values more important or desirable than others can help the system of care interact more successfully with differing cultures. In the system of care, awareness and acceptance of differences in communication, life view, and definition of health and family are critical to the successful delivery of services.

CULTURAL SELF-ASSESSMENT

The system of care must be able to assess itself and have a sense of its own culture. When planners and administrators understand how that system is shaped by culture, then it is easier for them to assess how the system interfaces with other cultures. System leaders can then choose courses of action that minimize cross-cultural barriers. For example, if "family" refers to nuclear families in one culture and in another culture "family" denotes

extended family, then concepts such as "family involvement" will require some adjustment or they simply will not work. Only by better knowing the culture of the existing system of care can the complexities of cross-cultural interfacing be understood.

DYNAMICS OF DIFFERENCE

What occurs in cross-cultural system interactions might be called the "dynamics of difference." When a system of one culture interacts with a population from another, both may misjudge the other's actions based on learned expectations. Each brings to the relationship unique histories with the other group and the influence of current political relationships between the two groups. Both will bring culturally-prescribed patterns of communication, etiquette, and problem solving. Both may bring stereotypes or underlying feelings about serving or being served by someone who is "different." The minority population may exhibit behaviors expressing tension and frustration that the system is uncomfortable with. It is important to remember this creative energy, caused by tension, is a natural part of cross-cultural relations, especially when one of the cultures is in a politically dominant position. The system of care must be constantly vigilant over the dynamics of misinterpretation and misjudgment. Historic distrust is one such dynamic that can occur between a helper of the dominant society and a client of a minority community (Lockart, 1981; Good Tracks, 1973). Part of what they bring to the helping relationship is the history of the relationship between their peoples.

Without an understanding of cross-cultural dynamics, misinterpretation and misjudgment are likely to occur. It is important to note that this misunderstanding is a two way process--thus the label "dynamics of difference." These dynamics give cross-cultural relations a unique character that strongly influences the effectiveness of the system. By incorporating an understanding of these dynamics and their origins into the system, the chances for productive cross-cultural interventions are enhanced. When people of any culture violate the norms of another there are consequences. A range of examples are provided in the practice and service adaptation sections of this monograph.

INSTITUTIONALIZATION OF CULTURAL KNOWLEDGE

The system of care must sanction and in some cases mandate the incorporation of cultural knowledge into the service delivery framework. Every level of the system needs accurate information or access to it. The practitioner must be able to know the client's concepts of

health and family as well as be able to effectively communicate. The supervisor must know how to provide cross-cultural supervision. The administrator must know the character of the population the agency serves and how to make services accessible. The board member or bureau head must be able to form links with minority community leaders so as not to plan ill-fated interventions. Mechanisms must be developed within the system to secure the knowledge it requires. The development of knowledge through research and demonstration projects must be made possible. Networks must be built, lines of communication must be opened, and the structure and process of the system must adapt to better respond to the needs of all children. The system must provide cultural knowledge to the practitioner. Information about family systems, values, history, and etiquette are important. However, the avenues to such knowledge are as important as the knowledge itself. The practitioner must have available to them community contacts and consultants to answer their culturally-related questions.

ADAPTATION TO DIVERSITY

Each element described here builds a context for a cross-culturally competent system of care. The system's approach may be adapted to create a better fit between the needs of minority groups and services available. Styles of management, definitions of who is included in "family," and service goals are but a few of the things that can be changed to meet cultural needs. Agencies understanding the impact of oppression on mental health can develop empowering interventions. For example, minority children repeatedly receive negative messages from the media about their cultural group. Programs can be developed that incorporate alternative, culturally-enriching experiences and that teach origins of stereotypes and prejudices. By creating such programs, the system can begin to institutionalize cultural interventions as a legitimate helping approach. Only as professionals examine their practice and articulate effective helping approaches will practice improve. Agencies engaging in these efforts add to the knowledge base.

Becoming culturally competent is a developmental process for the individual and for the system. It is not something that happens because one reads a book, or attends a workshop, or happens to be a member of a minority group. It is a process born of a commitment to provide quality services to all and a willingness to risk.

A VALUE BASE FOR CULTURAL COMPETENCE

A system of care which is accessible, acceptable, and available to children of color who are emotionally handicapped must be based on a set of underlying values. The literature reveals several common values. These values might be stated as basic assumptions which, when drawn together, provide a foundation for policy, practice, and attitudinal development. It is assumed that a culturally competent system of care:

- Respects the unique, culturally-defined needs of various client populations (Angrosino, 1978; Beane, Hammerschlag, and Lewis, 1980; Cingolani, 1973; Cross, 1986a; Fields, 1979; Gary, 1987a; Higginbotham, 1984; Kurtz and Powell, 1987; McDonald, 1987; Red Horse, 1980; Sack, Beiser, Clarke, and Redshirt, 1985; VanDenBerg and Minton, 1987; Hanley and Barling, 1981).

- Acknowledges culture as a predominant force in shaping behaviors, values, and institutions (Campfens, 1981; Comer and Hill, 1985; Hawkins and Salisbury, 1983; Spurlock, 1986);

- Views natural systems (family, community, church, healers, etc.) as primary mechanisms of support for minority populations (Flaskerud, 1986b; Flaskerud, 1988; Campfens, 1981; Owan, 1982; Kumabe, Nishida, and Hepworth, 1985; Tolmach, 1985);

- Starts with the "family," as defined by each culture, as the primary and preferred point of intervention, (Beane, Hammerschlag, and Lewis, 1980; Cingolani, 1973; Cross, 1986a; Fields, 1979; Hale, 1980; Red Horse, 1980; Nobles, Goodard, Cavil, and George, 1987).

- Acknowledges that minority people are served in varying degrees by the natural system (Beane, Hammerschlag, and Lewis, 1980; Cingolani, 1973; Cross, 1986a; Fields, 1979; Hale, 1980; Red Horse, 1980);

- Recognizes that the concepts of "family," "community," etc. are different for various cultures and even for subgroups within cultures;

- Believes that diversity within cultures is as important as diversity between cultures (Norton, 1978; Lum, 1986);

- Functions with the awareness that the dignity of the person is not guaranteed unless the dignity of his/her people is preserved;

- Understands that minority clients are usually best served by persons who are part of or in tune with their culture (Barrera, 1978; Flaskerud, 1986b; Chin, 1983; Ryan, 1980; Korchin, 1980; Gallegos, 1982; Higginbotham, 1984; Nuttall, Landurand, and Goldman, 1984; Rueda, 1984; Lynch and Stein, 1987);

- Acknowledges and accepts that cultural differences exist and have an impact on service delivery (Campfens, 1981; Comer and Hill, 1985; Hawkins and Salisbury, 1983; Spurlock, 1986; Munchin, Montalvo, Guerney, Rosman, and Schumer, 1976).

- Treats clients in the context of their minority status which creates unique mental health issues for minority individuals, including issues related to self-esteem, identity formation, isolation, and role assumption (Chin, 1983; Solomon, 1987; Flaskerud, 1986b; Flaskerud, 1988; Hendricks, 1987; Tolmach, 1985; Kumabe, Nishida, and Hepworth, 1985; Owan, 1982; Campfens, 1981);

- Advocates for effective services on the basis that the absence of cultural competence anywhere is a threat to competent services everywhere;

- Respects the family as indispensable to understanding the individual, because the family provides the context within which the person functions and is the primary support network of its members (Flaskerud 1986b; Kenyatta, 1980; Red Horse, 1980; Higginbotham, 1984; Carrasquillo, 1986);

- Recognizes that the thought patterns of non-western European peoples, though different, are equally valid and influence how clients view problems and solutions;

- Respects cultural preferences which value process rather than product and harmony or balance within one's life rather than achievement (Angrosino, 1978; Beane, Hammerschlag, and Lewis, 1980; Cingolani, 1973; Cross, 1986a; Fields, 1979; Hale, 1980; Red Horse, 1980; Higginbotham, 1984);

- Acknowledges that when working with minority clients process is as important as product;

- Recognizes that taking the best of both worlds enhances the capacity of all;

- Recognizes that minority people have to be at least bicultural, which in turn creates its own set of mental health issues such as identity conflicts resulting from assimilation, etc.;

- Functions with the knowledge that behaviors exist which are adjustments to being different (Chin, 1983); and

- Understands when values of minority groups are in conflict with dominant society values.

These assumptions are the starting point for this discussion of the cultural competence model. It is a model based on the belief that it is okay to be different and that the system of care can be enhanced for everyone by making it more responsive to the needs of minority children.

CHAPTER IV: DEVELOPING CULTURAL COMPETENCE

Systems, agencies, or professionals do not start out being culturally competent. Like other types of competence, cultural competence is developed over time through training, experience, guidance, and self-evaluation. As stated earlier, attitudes, policy, and practice must all come together in a congruent whole called cultural competence. Attitudes can be cultivated through training, modeling, and experience. Policy evolves through research, goal setting, and advocacy. Practice grows with information, training, and the development of new alternatives. Change occurs in a complex interplay between practice and policy set in the context of politics and the culture of the system. This section is designed to address the question of how a culturally competent system of care might be developed.

The "system" and its component parts have evolved over the last decade. The area of cultural competence has been no exception. The material that follows is a discussion of some concrete actions which some agencies have found useful in improving their services to minority clients. No one of the actions make an agency culturally competent. Rather, the more an agency develops an aggregate of these and other similar actions, the further that agency moves toward the positive end of the continuum.

Movement toward the positive end of the continuum is necessary at every level of the system or agency. The policymaking, administrative, practice, and even the consumer levels are each arenas for growth. This section has been organized around each of these levels.

POLICYMAKING LEVEL

The policymakers or planners of services may be board members of private agencies, public agency officials, legislators, and commissioners, or advisory committee members. Anyone who has a role in the shaping of policy might be included. A number of actions at this level are possible. First and foremost is community involvement (Angrosino, 1978; Flaskerud, 1986b; Brown, E.F., 1977; Ryan, 1980; Lutz, 1980; Owan, 1982; Wilkinson, 1980; Gallegos, 1982; McDiarmid, 1983; Higginbotham, 1984; VanDenBerg and Minton, 1987). Minority community persons can be recruited and asked to serve on boards, advisory committees, and commissions that already exist in the agency or system. Special task forces or advisory groups can be created using the representatives of minority

communities to study and address issues of that particular community. In addition, an agency might create an evaluation committee and submit its cross-cultural performance to minority community review. However the agency or system chooses to do so, minority community involvement is critical to the development of policy that is responsive to the needs of the community. To achieve this level of community involvement, the policymaker will need to establish linkages with existing minority networks.

Policymakers can set standards for cross-cultural services. An agency board may develop standards it expects its employees to follow. Standard-setting bodies can incorporate cultural competence into existing standards for services delivered by member agencies. States having licensing standards for mental health professionals might add cultural competence to the required skills of the profession. Training institutions also are subject to standards and have already benefited from this approach. Whatever the level, it is essential to determine what the standard should be through self-assessment and community input.

Training policies that sanction, and in some cases require participation in training that builds cultural knowledge and skills, can enhance cultural competence. Planners must also commit the resources to implement such policies and consult their cultural advisors on the necessary content (Cameron and Talavera, 1976; Zane, Sue, Castro, and George, 1982). It is not enough to require employees to get such training. The governing body must educate itself to the dynamics of difference, and develop some cultural knowledge in order to make decisions and take actions that are not ethnocentric. Training for board members on cultural competence can help avoid failures which inhibit further development and misguided efforts to rescue minority children.

Policymakers often use research findings to guide their decision making. Policy can be implemented that ensures data are kept on minority populations, that research is monitored (First, Roth, and Arewa, 1988; Ryan, 1980; Manson and Shore, 1981; Owan, 1982; Rueda, 1984; Taylor, 1979; Meinhardt and Vega, 1987) to avoid cultural bias or intrusion, and that minority researchers and research techniques are employed.

A decision-making structure in a system or agency that is flexible and empowers less powerful segments of the community contributes to the minority voice being heard. Agencies can adopt policies that allow minority participation in decision making (Angrosino, 1978; Flaskerud, 1986b; Brown, E.F., 1977; Ryan, 1980; Lutz, 1980;

Wilkinson, 1980; Owan, 1982; Gallegos, 1982; McDiarmid, 1983; Higginbotham, 1984; VanDenBerg and Minton, 1987).

At the legislative level, policy can be both integrated into existing laws and be formulated in new laws. Legislators can be careful to evaluate legislation for methods of improving services for everyone, while enhancing services for minority children. Again, community input is essential.

Funding mechanisms and funding paths can be adapted to improve service access for minority children. For example, through the use of contracting, public agencies can put dollars into the hands of minority service providers who might not otherwise be able to respond to community need. Public services can often be delivered more cost effectively by community-based agencies.

Funding can be used as an incentive for developing cultural competence. Policies encouraging the improvement of services to minority children have clout when they are attached to funding. Funding agencies, such as the United Way and federal, state, and local governments, all have the capacity to greatly influence the development of cultural competence through placing service requirements on recipients of the funds. Funding sources are increasingly using these means as an incentive for agency cultural competence development.

Progress at the policy level might be in the form of a written mission statement (Campfens, 1981; Comer and Hill, 1985; Spurlock, 1986; Hawkins and Salisbury, 1983) and a comprehensive plan to develop culturally-competent services. Actions such as incorporating cultural competence development into an agency's five year plan can help the policymaker break the process into manageable parts with reasonable timelines. As each policy of the agency is examined or revised, it is studied for its impact on service delivery to the minority population. Positive changes are incorporated systematically and cultural competence becomes institutionalized into the structure of the agency itself. In this way cultural competence does not become an "add on" but rather an integral part of the operation.

An agency may also enter into concrete actions such as resource development and program fostering. This means the agency actively works in conjunction with minority community members to enable the creation and healthy growth of a service. Established agencies can

assist in the startup and nurturance of new minority programs and then spin them off to full community self-control (Cohen, 1984; VanDenBerg and Minton, 1987). Such agencies use their power and influence to empower the minority community to improve service delivery on its own behalf.

None of these ideas are new concepts. Most have been tried or are in use to varying degrees across the country. They are not the only possibilities. What is new is the idea that as these actions come together in an agency's policymaking body, the agency becomes more competent to make policy for services to minority populations.

ADMINISTRATIVE LEVEL

The administrative level of service delivery is made up of agency directors, managers, department heads, and a variety of other people in both public and private organizations. This level interprets and implements policy in addition to creating it. Responsible for most aspects of the agency or public department, this level has many opportunities to move the organization toward cultural competence. It is at the administrative level that the commitment to a culturally competent system of care must be embraced. By accepting this commitment and communicating this to staff in organizational goals and objectives, the administrative level provides credence and direction for the development of cultural competence. The suggestions listed below may be more suited to either the public or private setting but could be adapted to either.

The administrator's primary role is to set the context for the development of cultural competence. Essential to this process is some form of agency self-assessment. Such a self-assessment might be formal or informal but includes several basic elements. Agencies need to determine the demographic make-up of their service area and define the client population. A comparison of actual client population and community demographics gives some indication about directions for planning. Administrators will want to know if their staff and governing board are representative of the population to be served. Is the agency accessible to all segments of the community physically and culturally? Is the philosophical orientation of the agency compatible with the belief system of the community to be served? For example, an agency may be family centered or individually focused. Are the intake procedures compatible with the needs of the cultural groups to be served? For example, some groups may distrust or avoid written forms which some agencies require to be filled

out prior to service delivery. The self-assessment should address whether the agency has the capacity to adapt its services to meet the needs of the minority client population.

Agencies can ensure that minority people are recruited and retained on the staff. Supporting minority students in institutions of higher learning is one means of recruitment which answers the agency's need for minority staff, but at the same time empowers the minority individual. Agencies can also change hiring practices to ensure that non-minority staff are culturally competent or willing to become so. By including questions in the interviewing process about cultural differences and by requiring work experience with minority populations, agencies can screen potential employees for cultural knowledge and attitudes. When developing job descriptions, administrators can include cultural competence as a qualification for the position. Such qualifications might include being able to communicate with the client in their native language or dialect, awareness of cultural values and beliefs, the ability to use natural helpers from the community, a willingness to be flexible, and willingness to spend time in the minority community and examine one's own cultural biases. When hiring minority staff, academic training is important, but should not be the only criteria for judging the capacity to deliver competent services. Agencies can develop criteria in which community recognition of a person as an effective helper can be considered in the hiring process or paraprofessional positions can be established to effectively utilize the uncredentialed.

Most agencies that provide training on minority issues/concerns or on cultural competence concentrate on developing cultural knowledge. Training should also focus on the function of culture in a person's life, the dynamics of difference, and how to adapt skills to fit the client's needs. Community "experts" who may not be credentialed, but have the respect of the community, are excellent training resources. Training should occur in both workshop settings and on-site in the community. Orientation to the minority client's community should be mandatory. Such a process would include orientation to both formal and informal community resources, to information about the history of the minority group or groups served, and to predominant cultural variables of the client population. Training needs to be recurrent and comprehensive. Both the staff and community should participate in the selection of content. Rewards can be built into the system for those who obtain additional training. Some agencies may want to focus their training on workers designated within the agency as cultural resource persons.

Personnel policies can also be adapted to make an agency more culturally competent. Non-discriminatory policies can also be culturally sensitive. For example, leave time can be adjusted to accommodate cultural differences in holidays or an important community or family event. Career advancement opportunities can be built into the system as well as incentives and opportunities for minority paraprofessional staff to become credentialed. Staff evaluations may be used to enhance an agency's cultural competence. Evaluations can include sections that rate an employee's responsiveness to the unique needs of clients of various cultures. Agencies can require mandatory continuing education aimed at improving cross-cultural skills.

Program evaluations can specifically target minority clients to determine their perceptions of the agency's effectiveness. Both the internal and external review of efforts to develop cultural competence will help an agency modify or change program goals as necessary.

The accessibility of services to minority communities can be improved through geographically locating services within the relevant communities (Owan, 1982; Flaskerud, 1986b). Such community-based services must be located in a place people frequent or recognize as a helping facility (e.g., schools, churches, temples, recreation centers, storefronts, and their own homes). Services should be available in some agencies on a 24-hour basis. Clients should feel secure that they will not be rejected or punitively discharged because of their minority status. Staff should be able to provide collateral as well as direct services (Flaskerud, 1986b; Brown, P.A., 1978; First, Roth, and Arewa, 1988; Comer and Hill, 1985; Edwards and Edwards, 1980; Lewis and Ho, 1975; Gallegos, 1982; Kurtz and Powell, 1987). Services should also be designed in such a way as to enable workers to help clients negotiate the service system. Practice should include attention to basic human needs as well as intrapsychic processes. The family must be included in the treatment process. Agencies must be flexible in their definition of "family" and work with family systems as defined by the culture of the client.

Administrative staff also have the capacity to adapt physical facilities to be more inviting to minority clients. The environment should be comfortable and acceptable to a variety of cultures. Art work may be displayed within the facility to reflect the culture or cultures of the community. Agencies may want to consider locating facilities in settings that are non-threatening and not usually or exclusively associated with mental health services. Reception services are particularly important and, as such, staff assigned to these services need careful screening for cultural sensitivity. When a specific culture makes up a

identifiable segment of the client population, an agency may set aside a room in which the decor is specific to that culture. Clients and community members should participate in the process to ensure the appreciation of cultural artifacts. Such actions help minority clients feel that their culture is valued and respected.

Administrators can ensure that data regarding services to minority clients are collected and used in planning and evaluating the agency's activities. That data should be made available to the community in the form of special or annual reports.

Administrative staff also have the capacity to develop new approaches or adjust existing ones. Efforts to make services fit the client rather than the client fit the service are useful (Flaskerud, 1986b; Campfens, 1981; Flaskerud, 1988; Owan, 1982; Hendricks, 1987; Tolmach, 1985; Kumabe, Nishida, and Hepworth, 1985). Programs such as home-based models identify the needs of the family and then seek to meet those needs. The agency should be able to respond to the needs of the family as the family perceives them. Flexibility and the capacity to outreach and link to informal systems are essential. Because of the existing differential application of services, agencies may want to design program components that capture minority children entering the juvenile justice or other service systems at an earlier point. Agencies should address alcohol and drug abuse or other issues threatening to the community. Another possible service adaptation is the incorporation of client advocacy into practice. Often the minority client's basic needs must be addressed before psychotherapeutic services can be effective. Finally, agency administrators can find ways to make use of the natural networks of the minority community. Through written agreements, systematic communication, and sustained formal and informal contact, administrators can encourage agency access to natural helping networks in the community.

Administrators responsible for areas such as contracting or issuing requests for proposals can require that contractors or grantees meet certain cultural competence requirements. Using a self-assessment scale, such as the one developed by the Research and Training Center of Portland State University, administrators could determine the position of contractors and grantees on the cultural competence continuum. Where indicated, contractors or grantees would be required to specify the manner in which they would move to the next higher level(s) of the cultural competence continuum. Under a weighted rating system, positive points would be designated for approaching and achieving higher levels on the cultural competence continuum. Review procedures and contract monitoring may

also incorporate cultural competence concepts. For example, staffing requirements can be designed requiring that staff be trained in culturally competent practice and be representative of the community served. Administrators also have a role in the development and implementation of licensing and recertification of licenses to perform certain functions within the system of care. Guidelines for incorporation of cultural competence can be institutionalized through the licensing process. Actions at this level provide strong financial incentives for change. They must, however, be coupled with guidelines and resources that enable programs to respond positively.

While actions at the administrative level alone cannot bring an agency to cultural competence, they are key elements. Administrative personnel set the tone for the practice staff and provide the structure for the continuing development of effective services. The activities described above have been implemented in various degrees. Moreover, the activities described are only illustrative of the possibilities. Thoughtful, creative thinking on the part of agency staff may produce additional ideas that further the development of the agency's cultural competence.

PRACTITIONER LEVEL

Sound cross-cultural practice begins with a commitment from the worker to provide culturally competent services. To succeed, workers need an awareness and acceptance of cultural differences, an awareness of their own cultural values, an understanding of the "dynamics of difference" in the helping process, a basic knowledge about the client's culture, knowledge of the client's environment, and the ability to adapt practice skills to fit the client's cultural context. Five essential elements for becoming a culturally competent helping professional are described below.

- The first task in developing cross-cultural skills is to acknowledge cultural differences and to become aware of how they affect the helping process. While all people share common basic needs, there are vast differences in how people of various cultures go about meeting those needs. These differences are as important as the similarities. Acceptance that each culture finds some behaviors, interactions, or values more important or desirable than others can help the mental health worker interact more successfully with members of different cultures. In the helping process, awareness and acceptance of differences in communication, life view, and the definition of health and

family are critical to successful outcomes. The worker develops a dual perspective. This perspective is dependent in part on understanding the role of culture in one's own life. To develop an appreciation for difference, the worker must be willing to risk and to develop an awareness of their own degree of ethnocentrism.

- To fully appreciate cultural differences, workers must recognize the influence of their own culture on how they act and think (Sherover-Marcuse, 1987). Many people have never acknowledged how their day-to-day behaviors have been shaped by cultural norms and values and been reinforced by families, peers, and social institutions. How one defines family, determines desirable life goals, views problems, and even says hello is influenced by the culture in which one functions. A purposeful self-examination of cultural influences can lead to a better understanding of the impact of culture on one's own life (Sherover-Marcuse, 1987). Only then can the complexities of cross-cultural interactions be fully appreciated.

- The "dynamics of difference" (Slaughter, 1988) must be understood at the practice level. When a worker of one culture interacts with a client from another, both will bring to the interaction their own unique history with the other group and the influence of current political or power relationships between the two groups. Both will bring culturally-prescribed patterns of communication, etiquette, and problem solving. Both may bring stereotypes with them or underlying feelings about working with someone who is "different." The minority client may exhibit behaviors which are adjustment reactions to dealing with a culturally foreign or even hostile environment. One clear example of the dynamics of difference is when two persons meet and shake hands. If someone from a culture in which a limp hand is offered as a symbol of humility and respect (as in some Native American groups) shakes hands with a mainstream American male (who judges a person's character by the firmness of their grip), each will walk away with an invalid impression of the other. These dynamics strongly influence the helping relationship.

Some further examples follow to illustrate the point. Different cultures have different values about the meaning of silence. In the dominant culture silence is often regarded as resistance. In some American Indian and Asian cultures, silence is a way of showing respect and being polite. Such clients are often misjudged on the basis of their silence (Ho, 1976). Some forms of etiquette cause dynamics of difference. For example, some American Indian groups express politeness through maintaining an agreeable demeanor in a helping encounter. The worker may mistake this for acceptance and for rapport when in fact the client has little or no understanding of what the worker expects. In an encounter with an Hispanic family, a worker must be prepared to respect roles based on gender (Aragon de Valdez and Gallegos, 1982). Failure to address the male first will severely restrict what can be accomplished. In Asian families, failure to engage elders--especially elder males as the primary access to the rest of the family--will inhibit the helper's effectiveness (Ho, 1976). By incorporating an understanding of these dynamics and their origins into practice, workers enhance their chances for productive cross-cultural interventions.

- Productive cross-cultural interventions are even more likely when mainstream workers make a conscious effort to understand the meaning of a client's behavior within his or her cultural context. For example, asking, "What does the client's behavior signify in his or her group?" helps the worker avoid assessing a client based on the norms of the dominant society. Specific knowledge about the client's culture adds a critical dimension to the helping process. It is necessary to know what symbols are meaningful, how health is defined, and how primary support networks are configured. Culture is an essential element of every evaluation.

- Information that will add to the worker's knowledge is vital, but because of the diversity within groups, the average worker cannot achieve comprehensive knowledge. More important is knowing where or how to obtain the necessary detailed information for use in specific cases. Gaining enough knowledge to know what, who, and how to ask for information is a desirable goal (Green, 1982). Such knowledge must grow and change with the ever growing dynamic process which is culture. As in any discipline, this

requires staying abreast of contemporary theory, practice, and research. However, building a knowledge base is not an end in itself. The worker must be able to take the knowledge and use it to adapt the way in which services are delivered.

Each element described here builds a context for cross-culturally competent practice. The worker can adapt or adjust the helping approach to compensate for cultural differences. Styles of interviewing, who is included in "family" interventions, and treatment goals are but a few things that can be changed to meet cultural needs. When workers understand the impact of social and cultural oppression on mental health they can develop empowering interventions. For example, minority children repeatedly receive negative messages from the media about their respective cultural groups. Treatment can be provided that incorporates alternative, culturally-enriching experiences and teaches the origins of stereotypes and prejudices. By writing such interventions into treatment plans, practitioners can begin to institutionalize cultural interventions as legitimate helping approaches.

Only as professionals examine their practice and articulate effective helping approaches will practice improve. Each worker will add to the knowledge base, through both positive and negative experiences, developing his or her expertise over time.

Wilson (1982) listed 24 attributes, knowledge areas, and skills that are essential to the development of cultural or ethnic competence:

Personal Attributes

- Personal qualities that reflect "genuineness, accurate empathy, nonpossessive warmth" (Traux and Mitchell) and a capacity to respond flexibly to a range of possible solutions.

- Acceptance of ethnic differences between people.

- A willingness to work with clients of different ethnic minority groups.

- Articulation and clarification of the worker's personal values, stereotypes, and biases about their own and others' ethnicity and social class, and ways these may accommodate or conflict with the needs of ethnic minority clients.

- Personal commitment to change racism and poverty.

- Resolution of feelings about one's professional image in field which have systematically excluded people of color.

Knowledge

- Knowledge of the culture (history, traditions, values, family systems, artistic expressions) of ethnic minority clients.

- Knowledge of the impact of class and ethnicity on behavior, attitudes, and values.

- Knowledge of the helpseeking behaviors of ethnic minority clients.

- Knowledge of the role of language, speech patterns, and communication styles in ethnically distinct communities.

- Knowledge of the impact of social service policies on ethnic minority clients.

- Knowledge of the resources (agencies, persons, informal helping networks, research) that can be utilized on behalf of ethnic minority clients and communities.

- Recognition of the ways that professional values may conflict with or accommodate the needs of ethnic minority clients.

- Knowledge of power relationships within the community, agency, or institution and their impact on ethnic minority clients.

Skills

- Techniques for learning the cultures of ethnic minority client groups.
- Ability to communicate accurate information on behalf of ethnic minority clients and their communities.
- Ability to openly discuss racial and ethnic differences and issues and to respond to culturally-based cues.
- Ability to assess the meaning ethnicity has for individual clients.
- Ability to differentiate between the symptoms of intrapsychic stress and stress arising from the social structure.
- Interviewing techniques reflective of the worker's understanding of the role of language in the client's culture.
- Ability to utilize the concepts of empowerment on behalf of ethnic minority clients and communities.
- Capability of using resources on behalf of ethnic minority clients and their communities.
- Ability to recognize and combat racism, racial stereotypes, and myths in individuals and in institutions.
- Ability to evaluate new techniques, research, and knowledge as to their validity and applicability in working with ethnic minorities.

The practitioner can gain these skills and this knowledge through training and experience. The personal attributes can be developed through exposure to the positive aspects of minority cultures. Further, workers can develop relationships within minority communities with both professionals and natural helpers who can help facilitate their learning. Information is a strong tool in the development of cultural competence, and practitioners

will want to avail themselves of every opportunity to build their cultural knowledge. Such knowledge must, however, be coupled with a willingness to let clients and cultural groups determine their own future.

CONSUMER LEVEL

Families, as service consumers, also have a role in the development of the cultural competence of the system. Families can become more effective advocates for their children when they gain the skills to articulate the importance of their culture. Families and the groups that represent them can become effective advocates by preparing themselves with information about how the dynamics of difference operate and how a bicultural existence effects the mental health of their children. Families can also be resources in the system's training process. Families can accomplish this by talking about the natural networks and insisting that significant parts of their networks be included in the helping process for their children. For example, the family may ask that grandparents be involved in helping plan for a child's needs.

Groups of minority parents can help open lines of communication and advocate for changes to better meet their needs if necessary. Parents can enlist the support of larger civil rights advocacy groups so that broader forces can be brought to bear in the effort to improve services to minority children with emotional disabilities. Families encountering insensitive services can turn to each other for aid in interfacing with the system. As consumers become aware of services that are responsive to cultural needs, they can provide encouragement to other minority families to use the system. Families linked with other families can provide mutual support and help define mental health from their own perspective.

To summarize, each level of the service delivery system has a role in contributing to the cultural competence of the agency or system. As various actions at different levels are implemented, the agency moves toward greater cultural competence. As the agency moves it will encounter new challenges. For example, an agency hiring minority professionals will encounter issues of cross-cultural supervision. Growth along the path is not inevitable, however, and an agency and the system of which it is a part must always be aware of the tendency for institutions to reflect the values and attitudes of the societal context in which they exist. Since this country is far from being culturally competent, the

system of care will need to be especially diligent to move itself toward more effective services for minority children.

CHAPTER V: SERVICE ADAPTATIONS

The delivery of effective services cross-culturally requires that existing services be adapted to fit the needs of the targeted minority group or individual. The possible ways of adapting services are endless. Adaptation requires flexibility and creativity. Most service adaptations are not costly but should be approached thoughtfully and sensitively. Since there are great variations among the four minority groups considered here, it is essential to not create stereotypic responses. The service adaptations described in this section are intended to illustrate the application of the cultural competence philosophy. It is not being suggested that these are ways to serve all Blacks, all Asians, etc. Services should be adapted to fit the needs of the group and the individual client based on identity, degree of assimilation, and subcultural grouping. Including culture as a regular part of every case assessment or evaluation will help the worker determine the type of practice adaptations necessary. Community and professional minority consultation will help agencies know what types of structural, procedural, or policy adaptations to make. The system of care can work with grassroots, non-traditional agencies in a variety of ways. Many minority agencies have gotten their start with the aid and technical assistance of established agencies or publicly-supported efforts. In this section, both policy and practice adaptations are examined.

Agencies, practitioners, and researchers have documented successes and failures in their attempts to combat institutional racism. Four models frequently appear: (a) mainstream agencies providing outreach services to minorities; (b) mainstream agencies supporting services by minorities within minority communities; (c) agencies providing bilingual/bicultural services; and (d) minority agencies providing services to minority people.

The outreach model is one frequently used by agencies beginning to recognize their need to improve services to minority clients. The outreach model consists of a special effort to reach a target client population. Minority groups or communities are seen to require the same services as do mainstream groups; services are perceived as "color-blind." This model does not acknowledge the oppression minority groups face, and may appear paternalistic, no matter how well intended. When an outreach program fails to take into account local minority cultural norms and values, it is likely to be rejected by community members (Angrosino, 1978).

The mainstream agency support of services by minorities within minority communities model is relatively new. This model has been adopted by federal, state, and local agencies that previously attempted to serve minorities with services not specific to their cultural needs. Agencies using this model appear to believe that minority populations or communities are best served by trained natural helpers with nominal supervision by agency professionals. The model seems to acknowledge that mainstream services are culturally inappropriate for minority people, and that mainstream services and workers may inadvertently perpetuate an oppression of minority people through institutional racism. The concept of noninterference is a base for this model. This model has met with success in Canada (Cohen, Y., 1984) and in three Alaskan Native villages (VanDenBerg and Minton, 1987).

Bilingual and bicultural services are advocated by Barrera (1978), Dana (1984), and Gallegos (1982). These researchers suggest that linguistic and cultural barriers are best overcome through multicultural staff who have more than one language. In this model it is assumed that cultural groups adapt or react to each other and that no one culture is likely to remain unchanged. Therefore staff who identify with, participate in, or are members of two or more cultures are likely to provide a maximum level of service. Services in this model may be less dominated by one culture and be more egalitarian than mainstream-supported services. Clients are more likely to respond to staff of the same or similar culture, and staff are more likely to appropriately identify and address client needs.

Minority agencies providing services to members of minority communities without mainstream agency sponsors are few in number. These agencies appear to be based on the belief that not only do minority groups know what services they need, but they can most appropriately meet their own needs without mainstream agency involvement. Such agencies focus upon minority groups that live in specific cultural communities (such as the Alaskan Native villages) or that have recently left such communities and intend to maintain their cultural support system structures. As there is no mainstream involvement, the agency may not be as racially oppressive or paternalistic as some previously mentioned models. One successful program is the Urban Indian Child Resource Center in Oakland, California. The Center established Indian foster homes, developed a system of "family representatives" who work as service coordinators with families newly from the reservations, and offers homemaker "surrogate grandmothers" who provide family support (Fields, 1976). McDiarmid (1983) studied the Chevak Village Youth Association in western Alaska--another example of this model--and found that it played a distinct role in

prevention as youth developed their responsibility, sense of competency, and ability to locate and use resources.

Three of the four models described above base services on emphasizing cultural values and helping systems: mainstream-supported minority services within minority communities, bilingual/bicultural agencies, and minority agencies. These services seem to have a high rate of satisfaction (Cameron and Talavera, 1976; Charleston, 1987; Chestang, 1981; Fields, 1976; Gary, 1987a; Keefe, Padilla, and Carlos, 1979; Kenyatta, 1980; Lutz, 1980). By enhancing existing helping systems, cultural dissonance is reduced as mental and emotional health is increased. Many authors indicate the importance of local ownership of services in order to provide a maximum level of services for the highest level of satisfaction.

Assessing the type of services to provide to the minority populations of a particular area appears crucial to the reception and use of services by minority people. Similarly, minority communities seeking to meet their own needs or seeking an agency to provide services may benefit from an assessment process. Dana, Hornby, and Hoffman (1984) suggest an assessment of local norms. Angrosino (1978) suggests that assessing potential community responses may affect the type of services an agency might provide. Manson and Shore (1981) offer a research design to assess the need for service, types of service, and service delivery system.

Agencies striving for cultural competence should be willing to accept the values of the minority culture and to develop skills for working with the client population (Lutz, 1980). They should be aware of the leadership values of the minority culture (Lewis and Gingerich, 1980) and understand minority expectations of agencies (Gallegos, 1982).

In general, service adaptations should be designed so that the service fits the client in the context of their culture. Individualizing of case planning is essential; however, the individual cannot be viewed in isolation. He or she is part of a family, community, and culture. A minority client's unique needs are shaped by his or her culture. Helpers outside of the client's culture should avoid projecting their own culturally-defined needs onto the client and his or her family. Natural helping systems, such as extended family, healers, and other helpers, must be considered as additional components of the system of care.

The concepts of unconditional care and least restrictive alternatives should be applied in service adaptations. Adaptations that provide the minority family with a range of care alternatives from least restrictive to most restrictive provide a continuum of care that is currently lacking for most children. Programs can strive to provide a normalizing experience for minority clients in which normal is defined by the culture of origin. Service adaptations should also be characterized by being community-based with strong outreach components. To the extent possible, services should be home-based and aimed at preserving families. Services must address the whole person within the context of community and culture. The following components, while not an exhaustive list, should be considered as part of service adaptations for minority children and families: crisis intervention, individual or group counseling, task- and training-oriented homemaker services, financial planning, maintenance assistance, 24-hour service availability, health and mental health service access, food assistance and nutritional consultation, diagnostic and assessment services, employment services, drug and alcohol services, and independent living preparation.

To compensate for situations in which large numbers of minority children enter the system through more restrictive environments, it is important to identify such situations early so as to intervene in ways that would divert as many of these children as possible into appropriate treatment environments. Stronger interagency collaboration and aggressive outreach are possible solutions. Approaches such as "in-home" services are useful in bringing various elements of the system together to preserve families. Such services must be designed by and for the community and culture in which they will be applied. Two other possible approaches are early intervention and prevention. To provide these services, programs need to develop the mechanisms to identify children. To prevent the loss of these children in the system and to insure that they are appropriately served, agencies might adopt policies such as zero reject/no punitive discharge. Such programming would place an emphasis on normalization and on maintaining intact families. "Family" would be defined by the person or persons receiving services. Important concepts in service adaptation for minority children include: flexibility of service systems, outreach, prevention and early identification, home-based services, and family and culturally-centered case management.

Coordination among agencies is essential and interagency collaboration should include natural helpers and community systems. Models of service that follow the child and are flexible enough to recognize the family as the identified client can encourage the provision of appropriate services.

Below are several examples of possible service adaptations for specific cultures. Examples have been divided into some representative service elements for the sake of illustration. It is not an exhaustive list. Possible service adaptations are endless and may be as varied as the cultures served.

INTAKE AND CLIENT IDENTIFICATION

The service adaptations involving intake and client identification include recommendations primarily directed at the administrative level. Many agencies use written forms to gather social or developmental history during the intake process. The client may be responsible for completing a form either with or without a worker's help. Many people have learned to distrust that which is written (Lockart, 1981). Tens of thousands of Latinos, primarily in the Southwest, are undocumented (so called "aliens"). Many are very sensitive to filling out legal documents which they believe will ultimately serve as a means to deport them back to their country, and therefore the potential client will decline the service or complete the form inaccurately. They may feel uneasy about how information will be used, or not feel they can represent themselves well on a form. One service adaptation is to spend time with the client in polite social interaction prior to doing business. This helps establish person-to-person rapport that may be inhibited if the form comes first. If forms must be used, their use must be explained, including who reads them and why they are necessary. The worker should ask for the client's permission to record information and share what has been written. Personal contact with the worker who will actually provide the service is also useful. People are often reluctant to share their troubles with others. They bring a historic distrust into the encounter; consequently, the fewer people to whom they have to reveal themselves, the better.

The system often relies on the referral process to identify the client population. This pattern has helped create the differential service provision that exists today. This is particularly a concern for Black youth. Because Black youth end up more often in the juvenile justice system rather than in the mental health system, they tend to get caught in a system that is not necessarily appropriate to their needs. Without special service adaptations there is no mechanism in the system to correct this problem. One possible adaptation is an outreach to juvenile justice, youth diversion, or other programs to identify Black youth who could be better served in mental health settings (Hawkins and Salisbury, 1983). Interagency

collaboration models in which the service dollar follows the child might be effective in reducing differential treatment of minority youth.

One dilemma is how to get minority children who are emotionally disturbed into particular services. Methods of outreach and community education can be adapted for various communities. Programs reaching out to the Black community are most successful when they work through churches, social fraternities and sororities, community-controlled media, and community and civic leaders (Gary, 1987b). Reaching out to the Native American community requires a more personal approach using a door-to-door, neighbor and relatives network building process (Good Tracks, 1973). In the Hispanic community the process may call for the inclusion of natural helpers and clergy. The need for outreach is especially acute.

The Asian community presents a clear illustration of some of the issues to consider. Outreach in the Asian community may require a more formalized, face-to-face process of involving key community leaders, elders, clergy, and self-help associations (Gould, 1988; Sue and Morishima, 1982; Chin, 1982). Outreach to the Asian community is largely ignored because of the belief that the community takes care of its own. Recent research suggests that the low number of Asian people entering the mental health system is due more to culturally-defined, help-seeking patterns rather than to a lack of need. (Sue and Morishima, 1982). Cultural attitudes about bringing shame to one's family and formalized patterns regulating help-seeking powerfully affect the utilization of mental health services and require that adaptations be made in the ways in which children in need of treatment get access to the system. Some ways that have been suggested include locating service sites within the community. This approach has been shown to dramatically increase utilization rates (Catell, 1962; Murase, 1977). The use of bilingual media to inform the community is seen as particularly important to educate the community about services and (for more recent immigrants) how the system works (Li, 1972; Munoz, 1980).

One way in which the system of care does not fit well with minority community needs is the prevailing practice of labeling the child as the "identified client." In family and extended family-focused culture, this practice tends to restrict how services are provided and even how workers think about interventions. A possible alternative would be to identify the family as client. This would make the family the point of intervention and shape the services to fit their needs. Similarly, the means of financing services may be adapted to

allow more flexibility in the system of care so that the family unit can be served across system boundaries without a loss of continuity.

ASSESSMENT AND TREATMENT

Adaptations to assessment and treatment approaches are essential to improved services. The dynamics of difference can be most problematic at the assessment phase. The Latino child may have caretakers whom they refer to as "Mom" and "Dad" who may not legally be guardians. Indian mothers may leave younger children in the care of older children (Dana, 1981; Padilla and Ruiz, 1973). In Black families a man may not be an "official" part of the household but is an integral part of the family system (Zollar, 1985; McAdoo, 1978). In some Asian communities the primary caretaker for children can be someone other than the biological mother. In Latino and Indian groups, time concepts may be different and formal appointment times may be foreign concepts (Lewis, 1975). In minority communities in general, work hours, spiritual practices, or family obligations may conflict with mental health appointments. Each of these situations could be interpreted as weaknesses, resistance, or family dysfunction if the evaluator is not aware of the cultural behaviors of the client. Adaptations to the usual assessment process involve learning what is "normal" in the context of the client's culture.

Psychological testing needs to be interpreted in the context of the client's culture. For example, the Native American or Asian child may exhibit symbology in projective testing which is unique to his or her tribe or group and which should not be interpreted on the basis of norms established for the mainstream (Dana, Hornby, and Hoffman, 1984). Other forms of assessment must take precedence over the use of testing with most minority children. Interviewing and gathering collateral information from family and community resources is essential.

Asian Americans are often diagnosed and served incorrectly due to differences in the expression of emotional problems (Gould, 1988). Such problems are often somatized. Workers must be prepared to help the client address the concrete issue of the health problem before the emotional issues can be addressed (Tsui and Schultz, 1985).

For Black children the diagnostic label "conduct disorder" is overused. Practitioners must use this label carefully and learn the culturally different indicators for depression, attachment and loss issues, and attention deficit problems (Solomon, 1987; Gary, 1987a).

More important, they must be aware of how such labels tend to channel Black children toward a criminal justice treatment path as opposed to a mental health path.

Persons evaluating minority children should be aware of the behaviors typical of the bicultural encounter. When a minority family or individual encounters a system or helper who is different than they are, they will exhibit some adjustment behavior to that situation. Such families are likely to be more reserved than usual as they look for cues on how to act in this new situation. They may be apprehensive and fearful that the service provider will judge them negatively or be prejudiced against their racial or cultural group. They may try to fit in as best they can or display a false bravado as a defense against a potentially hostile environment. If the evaluator judges the client on the basis of such behavior, they may well diagnose the client as resistant, passive, or undersocialized. Workers can adapt their expectations to accept adjustments to difference as a standard part of every cross-cultural encounter. These behaviors are, in fact, healthy survival skills (Chin, 1983).

Assessment can also be biased by misinterpretations of language usage and emotional expressiveness. Behaviors such as eye contact, firmness of a handshake, tone of voice, or greetings are culturally dependent and varied. Evaluators run the risk of an incorrect assessment if they interpret the behavior only on the basis of what it means in the mainstream culture. For example, in some Native American groups children are taught to express their remorse about a misdeed by not looking at the adult who is correcting them. This behavior is opposite to the expected behavior in the mainstream and can be misjudged as resistance or sullenness.

Interventions can be planned to include the entire family system as defined by the client. In addition, the family system can be viewed in its cultural context. For example, Hispanic families often have a strong role definition. In families where the male head of household acts as spokesperson for the family, a worker will be more effective if they work through the spokesperson to set appointments and discuss treatment objectives (Aguilar, 1972). For many Asian families, one therapist for the entire family helps avoid disruption of family integrity. For minority families whose needs are economic as well as emotional, concrete and rapid relief from environmental stress is necessary if the family is to stay engaged in mental health services. Some clients will present a concrete issue to a worker to test their sincerity and their willingness to help (Lewis and Ho, 1975). The helper should be able to help the client address a variety of needs.

It can be helpful to assist clients and families in understanding their own situations in the context of the larger society. Culture can sometimes provide the basis for intervention. Many minority organizations have developed specific treatment approaches that incorporate culture as the core component. For example, the Afro-centric approach developed for Black youth or the Talking Circle approach to group work used by some Native American programs (Brown, 1981) help to build positive identity and self-esteem through use of cultural strengths. (See page 63 for definitions of these approaches). Some approaches focus on understanding racial history, others look at bicultural survival tasks, and still others focus on acculturation and its costs (Sue, D.W., 1981). Clients learn how they and their problems fit in the larger society and gain a sense of belonging and dignity (NWICWI, 1987).

COMMUNICATION AND INTERVIEWING

Effective service delivery is dependent on communication. Nowhere is this issue more keenly felt than by minority communities whose first language is not English. Hispanic, Asian, and some Native American groups are likely to be assessed in a language that is not their own and asked to talk about emotional issues for which English has no equivalence to such concepts in their native language. Services can be adapted by making bilingual services available to all who need it. Community educational materials, agency literature, brochures, and treatment plans should all be available in the first language of the client. When bilingual staff are not available, interpreters should be provided. The agency should avoid using the family's children as interpreters. Such use of children is contrary to the family norms of many Asian groups, which requires children to listen and obey (Ho, 1976).

One aspect of communication is etiquette. Workers in cross-cultural situations can adapt their practices to accommodate the rules of social decorum their clients practice. For example, if on a home visit in the Black community one is offered food, it is polite to accept. This also holds true for American Indian people as well. In most Hispanic groups, a period of social conversation is considered polite before conducting business. This polite exchange is necessary to develop the relationship and is referred to as "personalismo" (McRoy, 1985). A worker should address Black clients formally, by their last name, until invited to do otherwise. With Asian clients a worker should be prepared to answer polite but personal questions which may be used to seek some common ground for developing a

relationship (Tsui and Schultz, 1985). These bits of basic etiquette are easy to adapt to and learn and can even be discussed directly with the client.

Practitioners may also have to adapt to differing ways of conceptualizing problems and different orientations to time. For example, many Native American and Hispanic groups view mental health as directly related to the spiritual side of life and to imbalances in the forces that impact their lives (Sue, D.W., 1981). This is in contrast to the cause and effect theory base of the mental health system which values history as important to understanding the present. Workers can adapt their information-gathering skills to include the client's perception of the problem which may be much more present-oriented or spiritually-based. Agencies often find in developing networks in minority communities that the emphasis on time in the dominant society is not shared by the other culture. One means of dealing with this is to make it the subject of discussion and to negotiate compromises with which both sides can live.

Interviewing is one form of communication that can easily be adapted. Native American communication patterns are characterized by pauses between "turns at talk" that are longer than those common in the mainstream (Philips, 1983). Silence is considered a part of communication because words should be carefully chosen (Lewis, 1975; NWICWI, 1987). Workers can adapt their styles by simply remaining quiet and giving the client time to think through their responses. Direct questions are considered intrusive. Accordingly, questions or subject opening comments are sometimes more revealing (NWICWI, 1987). In Hispanic or Asian cultures, a family may have a spokesperson determined by sex or generation roles as defined by the culture. In these situations the interviewer should be prepared to speak through the spokesperson (Aguilar, 1972; Aragon de Valdez and Gallegos, 1982; Tsui and Schultz, 1985).

Only through the development of cross-cultural communications skills can the worker become more effective. Only a few examples have been given to illustrate this point. This kind of information is representative of the type of cultural knowledge helpers need to develop.

CASE MANAGEMENT

Culturally competent case management is an essential aspect of service delivery to minority children and youth with serious emotional handicaps and to their families. While it is evident that children and youth benefit from therapeutic interventions, many minority clients will need help in the form of concrete or tangible services (e.g., housing, employment, health and dental care, transportation, respite care, etc.). In such cases, the overarching goal is to coordinate, integrate, and maintain a network of services that, together with natural helping resources, establishes and supports a functioning balance between child, family, and environment (Young, 1987).

Many minority children, youth, and their families expect formal helpers to be able to deal with a variety of problems, and form their judgment of the helpers' skills, empathy, and commitment by how well workers handle what many clients see as "real life" problems. If the helper exhibits caring concern and an ability to help, the client is more likely to trust the worker's skill in dealing with more serious issues (Lewis and Ho, 1975).

Case management should be more than simply referring the child elsewhere. It may include speaking for and with both child and parent to representatives from other organizations, such as schools, mental health clinics, churches, juvenile courts, and recreational programs. The goal is to persuade other people to join a collaborative effort to design, develop, and sustain a system of care for the child and his family (Young, 1987). Case management should be seen as an opportunity to teach self-advocacy, to assess the client's strengths, and to learn about the client's natural support network (Green, 1982). Creating such a system of care will validate the client's (child and family) role in the treatment process, while relieving professionals of the burden of providing services in isolation from other professionals and the family's natural support network (Mason, 1987).

The informal support network presents a special challenge for the case manager. It is often the greatest resource available to the client and at the same time the least accessible to the formal helper. This dual system can work to the client's benefit if services can be coordinated to support one another. Sometimes the formal system only needs to not stand in the way of the natural system. For example, a Hispanic parent who wants to consult a natural healer about his or her child's emotional problems should not be prevented from

doing so. An agency might even be able to facilitate such an action through the use of paraprofessionals or special liaison persons (McRoy, Shorkey, and Garcia, 1985).

Other parts of natural networks can include churches, schools, and associations, but also less traditional agencies such as self-help, cultural enrichment, spiritual growth, or business organizations. These organizations often have valuable services to offer, including emergency support and volunteer assistance. They also fill an important need for socialization within one's own group. Case managers can learn the function of these groups and also turn to these groups for advice and consultation (Green, 1982).

OUT-OF-HOME CARE

Service adaptations in the area of out-of-home care are necessary to help curb the high placement rates of minority children (Stehno, 1982). Home-based service models are the most promising alternatives at this point (Stroul, 1988). Several minority agencies have adopted this model and converted it to fit the unique needs of their own communities.

One service model largely unfamiliar to the dominant society is the use of extended family placements. The Indian Child Welfare Act specifically begins with extended family as a placement preference (U.S.C., see 1901 et al, 1978). Many Indian tribes have developed services designed specifically to work with the unique needs involved in extended family placements. Any of the cultural groups that rely on an extended family kinship system can benefit from this service model. The flow of money, however, usually does not facilitate the model. In many states, the extended family cannot receive state reimbursement for such care. An example of a policy adaptation is a law passed in Oregon in 1987 that authorized foster care payments to relatives in Indian Child Welfare cases. This adaptation has greatly enhanced the capacity of the natural system to fulfill its natural function.

Transracial adoptions present a particularly difficult issue in service delivery. While non-minority couples still desire to adopt racial minority children, it remains in the minds of many minorities one of the greatest indignities leveled against them. The mental health issues of these children are thought to be severe but are undocumented. The adoptions sometimes fail and the child is left without the natural support system of their extended family or cultural group and without an adequately formed identity (Berlin, 1978). Service alternatives include extended family adoption, more vigorous recruitment campaigns for same race adoptive families, and long-term planned guardianship (NWICWI, 1987).

Family reunification services should also be considered. These alternatives must be coupled with policy changes that end the practice of transracial adoption and help focus resources on the preservation of families. There exists a need for a partnership between the system, the families of the children served, and the communities to which they belong. The effort of developing cultural competence needs to be coupled with the concept of families as allies. Out-of-home placement should not mean out-of-culture nor out-of-family if that culture or extended family can provide the needed support.

In summary, service delivery adaptations can be made at the policy or practice level and must be tailored to the needs of the population being served. The examples given here are intended to illustrate the concepts of developing cultural competence through a clustering of actions that impact attitude, practice, and policy. These are but a few of the possible actions and service areas that should be examined. New service technology is rapidly developing, and as each agency makes progress all benefit from the experience of the other. Several guiding principles are helpful in developing service adaptations:

Guiding Principles

1. The family, as defined by each culture, is the primary system of support and preferred point of intervention;

2. The system must recognize that minority populations have to be at least bicultural and that this status creates a unique set of mental health issues to which the system must be equipped to respond;

3. Individuals and families make different choices based on cultural forces that must be considered if services are to be helpful;

4. Practice is driven in the system of care by culturally-preferred choices, not by culturally-blind or culturally-free interventions;

5. Inherent in cross-cultural interactions are dynamics that must be acknowledged, adjusted to, and accepted;

6. The system must sanction and in some cases mandate the incorporation of cultural knowledge into practice and policy making;

7. Cultural competence involves determining a client's cultural location in order to apply the helping principle of starting where the client is and includes understanding the client's level of acculturation/assimilation;

8. Cultural competence involves understanding cultural preferences in order to support client self-determination;

9. Cultural competence functions with the recognition that, in order to provide individualized services, clients must be viewed within the context of their cultural group and their experience of being part of that group;

10. Cultural competence functions with the acceptance of a client's culture as it really is, without judgment, and adapts service delivery to fit the context within which the client functions;

11. Cultural competence involves working in conjunction with natural, informal support and helping networks within the minority community, e.g., neighborhoods, churches, spiritual leaders, healers, etc.;

12. Cultural competence extends the concept of self-determination to the community. Only when a community recognizes and owns a problem does it take responsibility for creating solutions that fit the context of the culture;

13. Culturally competent services seek to match the needs and help-seeking behavior of the client population;

14. Culturally competent services are supported and enhanced when the system of care functions as an integrated support network;

15. Community control of service delivery through minority participation on boards of directors, administrative teams, and program planning and evaluation committees is essential to the development of effective services;

16. An agency staffing pattern that reflects the makeup of the potential client population, adjusted for the degree of community need, helps ensure the delivery of effective services; and

17. Culturally competent services incorporate the concept of equal and nondiscriminatory services, but go beyond that to include the concept of responsive services matched to the client population.

CHAPTER VI: PLANNING FOR CULTURAL COMPETENCE

It is one thing to know what can be done and yet another to move the system to greater cultural competence. This section addresses making changes through planned initiatives and is designed to provide professionals with some action steps for implementation.

Change may occur in a system or agency by chance or by design. It can occur in large leaps or in incremental steps but change does not happen in isolation from the social, political, or economic environment of which the entity is a part. Large and small systems have both internal and external environments with their respective formal and informal politics. This reality requires that planning not be done in isolation from these environments.

Those who assume the task of implementing a plan for improved cultural competence can enhance their efforts through strategic planning. First, a careful assessment of the environment in which the change is desired should reveal the barriers to and resources for change. Second, building a support base for the desired change will facilitate action. Third, finding or developing the resources needed to aid implementation will give the organization the tools with which to work. Fourth, understanding and maintaining key leadership involvement will insure that the issue stays on the agenda. Finally, development of a mission statement and concrete action steps will keep the plan realistic and workable. A discussion of each of the planning tasks follows.

ASSESSING THE ENVIRONMENT

The assessment of the environment for the purpose of planning to implement cultural competence must focus on the attitudes, policies, and practices of the organization and the context within which it operates regarding people not of the dominant culture. In scanning the larger environment, the planner must be particularly aware of the existing community norms and values about people who are non-Caucasian. Since organizations tend to reflect the environment in which they exist, there is a natural tendency for organizations to gravitate towards the values of the community at large. If a planner is trying to move an agency toward cultural competence in a community that has historically been racist, the task will likely be more difficult. If there are advocacy groups in the larger community, the planner may find alliances which might not ordinarily be regarded as resources.

Within the organization the planner will assess the cultural competence level by looking at policymaking, minority group access to services and decisionmaking, and by the degree to which practitioners within the organization can and do adapt services to meet the unique cultural needs of the minority client. Hiring practices, training policies, and the cultural make-up of the administration and staff will all provide some indication of the organization's readiness to move toward greater cultural competence. Regardless of the level of cultural competence, there are several factors that--if assessed--will help the planner know how to proceed:

- The planner will want to assess the administrative style of key administrators. Autocratic versus democratic administrative styles will influence how planning will occur and influence the types of internal and external support necessary to bring about the desired change.

- The planner will need to know what the resources are within and outside the organization that can promote change. Those resources may be existing, potential, or may need to be developed.

- The planner will want a realistic picture of his or her own sphere of influence and how his or her own attitudes and values are viewed by others. The planner's sphere of influence includes his or her capacity to influence, ability to get the issue on the agenda, and ability to transfer information through training and communication.

- The planner must be aware of which avenues must be impacted to bring about the desired change. Who must be influenced and how to influence them is critical. Knowing what will influence different parts of the organization is also essential.

- The planner will want to know how decisions are made, how resources are allocated, and how results are usually produced in the organization. He or she will need to know who the key stakeholders are in any change and what the likely reactions will be to efforts to improve cultural competence.

- Finally, the planner will need information on existing and potential coalitions within the organization and how coalitions function to bring about or block change.

Equipped with this range of knowledge, the planner of improved cultural competence can concentrate on the development of support, leadership, and resources.

DEVELOPING SUPPORT

In developing support for change, the planner informs, sensitizes, and helps clarify values within the organization in order to develop a constituency. Outside the organization the planner looks for allies, advocates, and role models. It is essential that the planner keep the community informed and involved while helping the organization articulate its values in such a way as to make it clear to everyone in the environment that development of cultural competence makes good sense and is beneficial for everyone. Some of the steps a planner can take are outlined below:

- The planner will want to initiate, in key forums, discussions of values and principles of the organization regarding minority clients. The endorsement of organizational leadership for the desired changes is essential and can most effectively be secured when the values and principles identified are presented in a positive and constructive fashion.

- The planner will want to sensitize and inform all levels of the organization about the issues. This may be done through training events, consultation, or through information sharing (i.e., printed materials). The goal of the planner is to create an environment in which the consensus is that the proposed change is "the right thing to do."

- The planner may want to develop a larger sense of support by involving the business community, religious community, parents, and media in the process. By finding and keeping allies in these arenas, the planner can help the external environment impact the organization.

- Finally, the planner may want to involve local, state, regional, or national advocacy groups (e.g., Children's Defense Fund, mental health associations, or service organizations). In this way the planner can increase available resources and disseminate information about the organization's efforts to others.

Building support is one of the key elements for implementing change. It is a process that takes time and must be done in such a way as to avoid creating defensive reactions. Most people in the mental health professions--regardless of culture--want to do the best possible job for their clients. If asked to participate in improving services for minority children, most people will be glad to, if given some direction on how to go about it. If confronted with their shortcomings, people are much less inclined to be supportive. Working together is the key. Building support networks is a useful process in getting people to work together.

RESOURCE DEVELOPMENT

Those planning for cultural competence will participate in the development of key resources for the process. Resources include people, sources of information, and tools with which to work when implementing planned activities. Process is as important as product when developing resources. Through agency self-assessment, demonstration of alternatives, and institutional change, the planner formulates and develops resources.

- The planner will want to become familiar with existing models for cultural competence. The concept behind a model must also be understood because the concept may be more transferable than the actual model. The planner must strive to help his or her organization evaluate and adapt existing models for application in their environment.

- The planner can help develop tools for the organization to reach its members, constituency, clients, etc. with information about cultural competence and to get community input.

- The planner will need to find or develop tools for agencies to reach their practitioners with training, consultation, and information. Locating and securing training materials, advisors, consultants, and trainers is a vital function.

- Finally, the planner may want to address long-range resources like higher education professional training curricula to insure that the future work force is culturally competent.

Numerous resources need to be developed and only a few have been mentioned here. Organizational leadership can help in resource development through commitment of financial resources to the process. It is essential, however, for the planner to show how cultural competence can be implemented with very little financial commitment.

LEADERSHIP DEVELOPMENT

Both formal and informal leadership is of importance to the planning process to develop cultural competence. Both play a significant role in the institutionalization of cultural competence in a system or organization. In the formal arena, the planner needs the support and sanction of the policymaking body and of the administration. Leadership from the policymaking level (i.e., board of directors, commissioners, etc.) can be formal or informal. Official sanction to pursue the development of cultural competence will give the most credibility to the effort, but, informally, members of policymaking bodies can provide leadership by repeatedly asking questions about the needs of minority clients, suggesting training topics, or calling for evaluation of services. At the administrative level, leadership may initiate action or may simply allow the planner the latitude to guide the process. Within the organization, informal leaders will have an effect on how readily new concepts are accepted, and the planner should be aware of the patterns of informal leadership. In developing leadership, the following should be considered:

- The planner will want to determine who is most willing and appropriate to act in a leadership capacity and then to help those people who play key roles in planning and implementation.

- The planner can determine the level and style of leadership provided by the administration and plan actions consistent with that style, if possible.

- The planner can find someone within the organization to champion the cause. The planner may also play this role but must bear in mind that combining the two roles may create resistance to change.

- The planner will need to examine each level of the organizational structure to find those allies who are supportive of the direction and to help form coalitions out of which leadership can logically develop.

Leadership for developing culturally competent services can come in many forms. The planner should examine the minority community for potential leaders in this effort as well and bring them into the planning process. By being aware of how leadership works in the organization, the planner can help develop the capacity to establish a more positive position on the cultural competence continuum.

MISSION AND ACTION

The role of the planner includes helping the organization articulate its values and establish a mission or goal statement to guide the planning process. By developing a statement that everyone can agree upon as a value statement of the organization, a sense of direction is established. Concrete action steps can then be planned:

- The planner can help isolate those activities that are the most feasible to initiate currently and those that should be left until a later date.

- The planner can examine the existing plans of the organization and determine how those plans might be modified to address cultural competence.

- The planner may develop a comprehensive plan for the improvement of cultural competence in conjunction with community and organizational representatives.

Planning for cultural competence involves assessment, support building, facilitating leadership, developing resources, and setting goals and action steps. While this process is not unique to the development of cultural competence, it is particularly well suited to the effort because of the scope and complexity of the issues. Such planning must be approached with the developmental nature of the acquisition of cultural competence in mind. Not all agencies will approach the issue in the same way and each will have a different timeline for development. Through the use of this or similar planning approaches, organizations can avoid feeling that the task is unmanageable, and each can develop at its own pace in ways that make sense in the context of the organization.

CONCLUSION

In conclusion, it is becoming increasingly clear that in order for the system of care to be successful in reaching CASSP goals, careful attention must be paid to the needs of minority children, families, and communities within the context of their culture. The system must plan, design, and implement services that are appropriate, accessible, and delivered in a "culturally competent manner."

This monograph, together with strategic planning on the part of policymakers, administrators, practitioners, and consumers, is therefore seen as a beginning step in laying the groundwork for meeting the challenge of effectively serving minority children who are severely emotionally disturbed. The monograph provides a philosophical framework and offers some practical ideas for improving service delivery to children of color who are severely emotionally disturbed at each level of the service delivery system.

Improving services to children of color becomes even more imperative when the rapidly changing demographic make-up of the nation is considered. It is projected that, by the year 2000, those now called minorities will outnumber what is now the majority in some states. Should such trends continue, the challenges that face the nation in planning and producing a system of care for children who are emotionally disturbed will change rapidly as well. The opportunity currently exists to plan and adapt in a thoughtful, culturally-sensitive way a culturally competent system of care which could greatly impact the improvement of services to minority children, youth, and their families. Thus, it is hoped this monograph will prove helpful to the field in addressing some of the challenges ahead especially in view of the changing demographics of the population and the need for the system of care to become more culturally competent.

DEFINITIONS

In the Afro-centric approach emphasis is placed on human development which is based upon an understanding of the natural order. The world is circular in that there is an interconnectedness, and whatever happens to one happens to all (Biti, 1969). The African "self" concept is defined as the "we," instead of the "I," emphasizing the notion of interdependence (Harvey, 1979). In the rites of passage for African American adolescents in the Sojourner Truth Adolescent Rites Society, adult members, for example, are required to sacrifice in their responsibility to assist and guide youth in aligning and re-aligning themselves with the natural order.

The Talking Circle is a form of group therapy in which people are typically seated in a circle. Sweetgrass, sage, or cedar is often briefly burned and passed among the participants to "purify" themselves in the smoke. Each participant is licensed to speak freely without fear of rejection or contradiction. The Talking Circle is closed by a joining of hands and brief prayer (Manson, 1986).

BIBLIOGRAPHY

Aguilar, I. (1972). "Initial Contacts with Mexican American Families." *Social Work*, v. 17(3): 66-70.

Angrosino, M.V. (1978). "Applied Anthropology and the Concept of the Underdog: Implications for Community Mental Health Planning and Evaluation." *Community Mental Health Journal*, v. 14(4): 291-299.

Aragon de Valdez, T. and Gallegos, J. (1982). "The Chicano Familia in Social Work." In Green, J.W., ed. *Cultural Awareness in the Human Services*, pp.184-208. Englewood Cliffs, NJ: Prentice-Hall, Inc.

Arredondo, R., Weddige, R.L., Justice, C., and Fitz, J. (1987). "Alcoholism in Mexican-Americans: Intervention and Treatment." *Hospital and Community Psychiatry*, v. 38(2): 180-183.

Attneave, C.L. (1969). "Therapy in Tribal Settings and Urban Network Intervention." *Family Process*, v. 8(2): 192-210.

Aylesworth, L., Ossorio, P., and Osako, L. (1980). "Stress and Mental Health among Vietnamese." In Endo, R., Sue, S. and Wagner, N., eds. *Asian Americans: Social and Psychological Perspectives*, Vol. II, pp.75-76. Palo Alto, CA: Science and Behavior Books.

Barrera, M. (1978). "Mexican-American Mental Health Service Utilization: A Critical Examination of Some Proposed Variables." *Community Mental Health Journal*, v. 4(1): 35-45.

Basu R., Basu, A., and Kesselman, M. (1978). "Racism, Classism, and Welfare: A View from the Bottom." *Catalyst*, v. 1(3): 24-35.

Beane, S., Hammerschlag, C.A., and Lewis, J. (1980). "Federal Indian Policy: Old Wine in New Bottles." *White Cloud Journal*, v. 2(1): 14-17.

Berlin, I.N. (1978). "Anglo Adoptions of Native Americans: Repercussions in Adolescence." *Journal of the American Academy of Child Psychiatry*, v. 17:387-388.

Berlin, I.N. (1983). "Prevention of Emotional Problems among Native American Children: Overview of Developmental Issues." In Chess, S. and Thomas, A., eds. *Annual Progress in Child Psychiatry and Development*, pp. 320-333. New York: Brunner/Mazel.

Biti, J. (1969). *African Religions and Philosophy*. Garden City, NJ: Anchor/DoubleDay and Company.

Bloombaum, M., Yamamoto, J., and Evans, Q. (1968). "Cultural Stereotyping amongst Psychotherapists." *Journal of Counseling and Clinical Psychology*, v. 32: 99.

Brown, E.F. (1977). "Self-Determination for Indian Communities: A Dilemma for Social Work Education and Practice." In Pierce, F.J., ed. *Mental Health Services and Social Work Education with Native Americans*, pp. 1-10. Norman, OK: University of Oklahoma.

Brown, P.A. (1978). "Differential Utilization of the Health Care Delivery System by Members of Ethnic Minorities." *Journal of Sociology and Social Welfare*, v. 3(5): 516-523.

Brown, S.A. (1981). *Cross-Cultural Alcoholism Treatment*. Unpublished paper. Portland, OR: Native Amercian Rehabilitation Association.

Cameron, J.D. and Talavera, E. (1976). "An Advocacy Program for Spanish-Speaking People." *Social Casework*, v. 57(7): 427-431.

Campfens, H. (1981). "Community Practice Related to Ethnicity." *Social Development Issues*, v. 2-3: 74-89.

Carrasquillo, A. (1986). "The Parent Factor in Teaching Language Skills to Limited English Proficient Learning Disabled Students." In Willig, A.C. and Greenberg, H.F., eds. *Bilingualism and Learning Disabilities: Policy and Practice for Teachers and Administrators*, pp. 53-68. New York: American Library Publishing Co.

Catell, S. (1962). *Health, Welfare, and Social Organization in Chinatown, New York City*. Report prepared for Chinatown Public Health Nursing Demonstration, Department of Public Affairs. New York: Community Service Society of New York.

Charleston, S. (1987). "Victims of an American Holocaust." *Sojourners*, v. 16(10): 32-33.

Chestang, L.W. (1981). "The Policies and Politics of Health and Human Services: A Black Perspective." In Johnson, A.E., ed. *The Black Experience: Considerations for Health and Human Services*, pp.15-25. Davis, CA: International Dialogue Press.

Chin, J.L. (1983). "Diagnostic Considerations in Working with Asian-Americans." *American Journal of Orthopsychiatry*, v. 53(1): 100-109.

Chin, R. (1982). "A Conceptual Paradigm for a Racial-Ethnic Community." In Sue, S. and Moore, T., eds. *The Pluralistic Society: A Community Mental Health Perspective*. New York: Human Sciences Press.

Christmas, J. (1982). "Trying to Make It Real: Issues and Concerns in the Provision of Services for Minorities." In Munoz, F. and Endo, R., eds. *Perspectives on Minority Group Mental Health*. Washington, DC: University Press of America.

Cingolani, W. (1973). "Acculturating the Indian: Federal Policies, 1834-1973." *Social Work*, v. 18(6): 24-28.

Cohen, Y. (1984). "Residential Treatment as a Holding Environment." *Residential Group Care and Treatment*, v. 2(3): 33-43.

Comer, J.P. and Hill, H. (1985). "Social Policy and the Mental Health of Black Children." *Journal of the American Academy of Child Psychiatry*, v. 24(2):175-181.

Commission on Indian Services (1984). *Summary of General Issues and Concerns Relating to State Human Resources Programs as Identified by the American Indian Community of Oregon.* Report of the Commission on Indian Services and Their Assessment of Human Resource Services to American Indians in the State of Oregon. Salem, OR.

Coyle, N. (1984). "Adoption Problems among Ethnic Groups: Lumbee Indian Children." *Residential Group Care and Treatment*, v. 2(1-2): 149-160.

Cross, T. L. (1986a). "Drawing on Cultural Tradition in Indian Child Welfare Practice." *Social Casework*, v. 67(5): 283-289.

Cross, T. L. (1986b). *Gathering and Sharing: An Exploratory Study of Service Delivery to Emotionally Handicapped Indian Children.* Portland, OR: Research and Training Center to Improve Services for Seriously Emotionally Handicapped Children and their Families and Northwest Indian Child Welfare Institute.

Cueller, I., Harris, L.C., and Jasso, R. (1980). "An Acculturation Scale for Mexican American Normal and Clinical Populations." *Hispanic Journal of Behavioral Sciences*, v. 2(3): 199-217.

Cummins, J. (1986). "Psychological Assessment of Minority Students." In Willig, A.C. and Greenberg, H.F., eds. *Bilingualism and Learning Disabilities: Policy and Practice for Teachers and Administrators*, pp. 3-14. New York: American Library Publishing Co.

Dana, R.H., ed. (1981). *Human Services for Cultural Minorities.* Baltimore: University Park Press.

Dana, R.H. (1984). "Intelligence Testing of American Indian Children: Sidesteps in Quest of Ethical Practice." *White Cloud Journal*, v. 3(3): 35-41.

Dana, R.H., Hornby, R., and Hoffman T. (1984). "Local Norms of Personality Assessment for Rosebud Sioux." *White Cloud Journal*, v. 3(2): 17-25.

Dawkins, M., Dawkins, M.P., and Terry, J.A. (1979). "Personality and Lifestyle Characteristics of Users and Nonusers of Mental Health Services in an Urban Black Community." *Western Journal of Black Studies*, v. 3(1): 43-52.

Devore, W. (1983). "Ethnic Reality: The Life Model and Work with Black Families." *Social Casework*, v. 64(9): 525-531.

Devore, W. and Schlesinger, E.G. (1981). *Ethnic Sensitive Social Work Practice.* St. Louis: C.V. Mosby.

Dew, N. (1984). "The Exceptional Bilingual Child: Demography." In Chinn, P.C., ed. *Education of Culturally and Linguistically Different Exceptional Children*, pp. 1-41. Reston, VA: ERIC Clearinghouse on Handicapped and Gifted Children.

Dodson, J. (1981). "Black Families: The Clue to Cultural Appropriateness as an Evaluative Concept for Health and Human Services." In Johnson, A., ed. *The Black Experience: Considerations for Health and Human Services*, pp. 41-52. Davis, CA: International Dialogue Press.

Draguns, J.G. (1981). "Cross-Cultural Counseling and Psychotherapy: History, Issues, Current Status." In Marsella, A.J. and Pedersen, P.B., eds. *Cross-Cultural Counseling and Psychotherapy* , pp. 3-27. New York: Pergamon Press.

Edwards, E.D. and Edwards, M.E. (1980). "American Indians: Working with Individuals and Groups." *Social Casework*, v. 61(8): 498-506.

Ellsworth, C., Hooyman, N., Ruff, R.A., Stam, S.B., and Tucker, J.H. (1980). *Towards a Feminist Model of Planning for and With Women*. Unpublished paper: Seattle, WA: University of Washington.

Endo, R., Sue. S., and Wagner, N., eds. (1980). *Asian Americans: Social and Psychological Perspectives*, Vol. II. Palo Alto: Science and Behavior Books.

English, R. (1974). "Beyond Pathology: Research and Theoretical Perspective on Black Families." In Gary, L., ed. *Social Research and the Black Community*. Washington, DC: Howard University Press.

Fanta-Hardy, C. and MacMahon-Herrara, E. (1981). "Adapting Family Therapy to the Hispanic Family." *Social Casework*, v. 62(3): 138-148.

Fields, S. (1976). "Folk Healing for the Wounded Spirit - Medicine Men: Purveyors of an Ancient Art." *Innovations*, v. 3(3): 12-18.

Fields, S. (1979). "A Life in the Crowd, A Trail of Concrete." *Innovations*, v. 6(3): 8-12.

"First Model Preschool Program Developed at Tucson for Handicapped Indian Children" (1971). *Journal of American Indian Education*, v. 10(3): 1-2.

First, R.J., Roth, D., and Arewa, B.D. (1988). "Homelessness: Understanding the Dimensions of the Problem for Minorities." *Social Work*, v. 33(2): 120-124.

Flaskerud, J.H. and Anh, N.T. (1988). "Mental Health Needs of Vietnamese Refugees." *Hospital and Community Psychiatry*, v. 39(4): 435-437.

Flaskerud, J.H. (1986a). "Diagnostic and Treatment Differences among Five Ethnic Groups." *Psychological Report*, v. 58(1): 219-235.

Flaskerud, J.H. (1986b). "The Effects of Culture-Compatible Intervention on the Utilization of Mental Health Services by Minority Clients." *Community Mental Health Journal*, v. 22(2): 127-141.

Freed, A.O. (1988). "Interviewing through an Interpreter." *Social Work*, v. 33(4):315-319.

Fujii, S. (1980). "Elderly Asian Americans and Use of Public Services." In Endo, R., Sue, S., and Wagner, N., eds. *Asian Americans: Social and Psychological Perspectives*, Vol. II, p. 221. Palo Alto, CA: Science and Behavior Books.

Gallegos, J. S. (1982). "Planning and Administering Services for Minority Groups." In Austin, J.J. and Hershey, W.E., eds. *Handbook on Mental Health Administration: The Middle Manager's Perspective*, pp.87-105. San Francisco: Jossey-Bass.

Gary L.E. (1983). "Utilization of Network Systems in the Black Community." In Johnson, A., ed. *The Black Experience: Considerations for Health and Human Services*, pp. 55-74. Davis, CA: International Dialogue Press.

Gary, L.E. (1987a). "Attitudes of Black Adults toward Community Mental Health Centers." *Hospital and Community Psychiatry*, v. 38(10): 1100-1105.

Gary, L.E. (1987b). "Religion and Mental Health in an Urban Black Community." *Urban Research Review*, v. 11(2): 5-7, 14.

Gaviria, M. and Stern, G. (1980). "Problems in Designing and Implementing Culturally Relevant Mental Health Services for Latinos." *U.S. Social Science and Medicine*, v. 14(B): 65-71.

Gilbert, M.J. and Cervantes, R.C. (1986). "Alcohol Services for Mexican Americans: A Review of Utilization Patterns, Treatment Considerations, and Prevention Activities." *Hispanic Journal of Behavioral Sciences*, v. 8(3): 191-223.

Gomez, E. and Cook, K. (1978). "Chicano Culture and Mental Health Services: Trees in Search of a Forest." In Gomez, E., ed. *Chicano Culture and Mental Health*. Our San Antonio, TX: Lady of the Lake University.

Good Tracks, J.G. (1973). "Native American Noninterference." *Social Work*, v. 18(6): 31-35.

Gould, K.H. (1988). "Asian and Pacific Islanders: Myth and Reality." *Social Work*, v. 33(2): 142-147.

Green, J.W., ed. (1982). *Cultural Awareness in the Human Services*. Englewood Cliffs, NJ: Prentice-Hall, Inc.

Guthrie, R.V. (1976). *Even the Rat Was White*. New York: Harper and Row.

Hale, J. (1980). *A Matter of Culture: The Educative Styles of Afro-American Children*. Reston, VA: ERIC Clearinghouse on Handicapped and Gifted Children.

Hammerschlag, C.A. (1982). "American Indian Disenfranchisement: Its Impact on Health and Health Care." *White Cloud Journal*, v. 2(4): 32-36.

Hanley, J.H. and Barling, P. (1981). "Brief Problem - Oriented Psychotherapy: A Model for Non-Traditional Clients." *Journal of Professional Psychology*, v. 12(5): 556-561.

Harvey, R.H. (1979). *A Comparison of African and Euro-American World Views: A Basis for Understanding Afro-American Male-Female Relationships*. Proceeds of the 11th Annual Conference of the National Association of Black Social Workers, pp. 124-128.

Hawkins, J.D. and Salisbury, B.R. (1983). "Delinquency Prevention Programs for Minorities of Color." *Social Work Research and Abstracts*, v. 19(4): 5-12.

Hendricks, L.E. (1987). "Some Reflections on Racial Comparative Research." *Urban Research Review*, v. 11(2): 4,15.

Herzog, E. (1970). "Social Stereotypes and Social Research." *Journal of Social Issues*, v. 26: 109-125.

Higginbotham, H.N. (1984). *Third World Challenge to Psychiatry: Culture Accomodation and Mental Health Care*. Honolulu: University of Hawaii Press.

Ho, M.K. (1976). "Social Work with Asian Americans." *Social Casework*, v. 57(3): 195-200.

Hopps, J.G. (1988). "Deja-Vu or New View." *Social Work*, v. 33(4): 291-292.

Hune, S. (1977). "U.S. Immigration Policy and Asian Americans: Aspects and Consequences." In *Civil Rights Issues of Asian and Pacific Americans: Myths and Realities*, pp. 283-291. Washington, DC: Government Printing Office.

Indian Child Welfare Act of 1978, U.S.C., Sec. 1901 et al.

Isaacs, M.R. (1986). *Developing Mental Health Programs for Minority Youth and their Families*. Washington, DC: Georgetown University Child Development Center.

Jenkins, S. (1981). *The Ethnic Dilemma in Social Services*. New York: The Free Press.

Jones, J.H. (1981). *Bad Blood: The Tuskegee Syphilis Experiment*. New York: Free Press.

Jones, D.M. (1978). "The Mystique of Expertise in Social Services: An Alaska Example." *Journal of Sociology and Social Welfare*, v. 3(3): 332-346.

Katz-Leavy, J., Lourie, I.S., and Kaufmann, R. (1987). "Meeting the Mental Health Needs of Severely Emotionally Disturbed Minority Children and Adolescents: A National Perspective." *Children Today*, v. 16(5): 10-14.

Keefe, S.E., Padilla, A.M., and Carlos, M.L. (1979). "The Mexican-American Extended Family as an Emotional Support System." *Human Organization*, v. 38(2): 144-152.

Kenyatta, M.I. (1980). "The Impact of Racism on the Family as a Support System." *Catalyst*, v. 2(4): 37-44.

Kim, T. (1980). "Statement on Census Issues--Impact and Reaction." In *Civil Rights Issues of Asian and Pacific Americans: Myths and Realities*. Washington, DC: U.S. Government Printing Office.

Knitzer, J. (1982). *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services*. Washington, DC: Children's Defence Fund:

Korchin, S.J. (1980). "Clinical Psychology and Minority Problems." *American Psychologist*, v. 35(3): 262-269.

Kramer, B.M. (1984). "Community Mental Health in a Dual Society." In Sue, S. and Moore, T., eds. *The Pluralistic Society: A Community Mental Health Perspective*, pp. 254-261. New York: Human Sciences Press.

Kumabe, K.T., Nishida,C., and Hepworth, D.H., eds. (1985). *Bridging Ethnocultural Diversities in Social Work and Health.* Honolulu: University of Hawaii School of Social Work.

Kuramoto, F.H., Morales, R.F., Munoz, et al (1983). "Education for Social Work Practice in Asian and Pacific American Community." In Chunn, J.C., Dunston, P.J., and Ross-Sheriff, F., eds. *Mental Health and People of Color: Curriculum Development and Change*, pp. 127-155. Washington, DC: Howard University Press.

Kurtz, L.F. and Powell, T.J. (1987). "Three Approaches to Understanding Self-Help Groups." *Social Work with Groups*, v. 10(3): 69-80.

LaFromboise, T.D. and Plake, B.S. (1984). "A Model for the Systematic Review of Mental Health Research: American Indian Family, a Case in Point." *White Cloud Journal*, v. 3(3): 44-52.

LaFromboise, T.D. (1988). "American Indian Mental Health Policy." *American Psychologist*, v. 43(5): 388-397.

Lee, E. (1979). "Mental Health Services for the Asian American: Problems and Alternatives." In *Civil Rights Issues of Asian and Pacific Americans: Myths and Realities*, pp. 734-756. Washington, DC: Government Printing Office.

Lefley, H.P. and Bestman, E.W. (1984). "Community Mental Health and Minorities: A Multi-Ethnic Approach." In Sue, S. and Moore, T., eds. *The Pluralistic Society: A Community Mental Health Perspective*, pp. 116-148. New York: Human Sciences Press, Inc.

Leigh, J.W., Jr. (1982). "Directions for the Future: The Ethnic Competent Social Worker." In Saalberg, E., ed. *A Dialogue on the Challenge for Education and Training: Child Welfare Issues in the 80s.* Ann Arbor, MI: National Child Welfare Training Center, University of Michigan.

Lewis, R.G. and Gingerich, W. (1980). "Leadership Characteristics: Views of Indian and Non-Indian Students." *Social Casework*, v. 61(8): 494-497.

Lewis, R.G. (1977). "Tribal Social Welfare-A Challenge to Creativity." In Peirce, F.J., ed. Mental Health Services and Social Work Education with Native Americans, pp. 25-33. Norman, OK: University of Oklahoma.

Lewis, R.G. and Ho, M.K. (1975). "Social Work with Native Americans." *Social Work*, v. 20(5): 379-382.

Li, F. et al (1972). "Health Care for the Chinese Community in Boston." *American Journal of Public Health*, v. 62: 537.

Lockart, B. (1981). "Historic Distrust and the Counseling of American Indians and Alaska Natives." *White Cloud Journal*, v. 2(3): 31-34.

Lorenzo, M. and Adler, D. (1984). "Mental Health Services for Chinese in a Community Health Center." *Social Casework*, v. 65(10): 600-609.

Lum, D. (1986). *Social Work Practice and People of Color: A Process-Stage Approach.* Monterey, CA: Brooks/Cole Publishing.

Lutz, F. (1980). *The Process of Native American Influence on the Education of Native American Children.* Paper presented at the Annual Meeting of the American Educational Research Association in Boston.

Lynch, E.W. and Stein, R.C. (1987). "Parent Participation by Ethnicity: A Comparison of Hispanic, Black, and Anglo Families." *Exceptional Children*, v. 54(2): 105-111.

Manson, S. (1986). "Recent Advances in American Indian Mental Health Research: Implications for Clinical Research and Training." In Miranda, M. and Kilano, H., eds. *Mental Health Research and Practice in Minority Communities: Development of Culturally Sensitive Training Programs* , pp. 51-89. Washington, DC: Dept. of Health and Human Services, Publication No. ADM 86-1466.

Manson, S.M. and Shore, J.H. (1981). "Psychiatric Epidemiological Research among American Indians and Alaska Natives: Methodological Issues." *White Cloud Journal*, v. 2(2):48-56.

Martinez, R., Norman, R.D., and Delaney, H.D. (1984). "A Children's Hispanic Background Scale." *Hispanic Journal of Behavioral Sciences*, v. 6(2): 103-112.

Mason, J.L. (1987). "The Personal Community." *Focal Point*, v.1(3): 8. Published by Research and Training Center, Regional Research Institute for Human Services, Portland State University.

McAdoo, H. (1978). "Factors Related to Stability in Upwardly Mobile Black Families." *Journal of Marriage and the Family*, v. 40(4).

McAdoo, H. (1982). "Demographic Trends for People of Color." *Social Work*, v. 27: 15-23.

McRoy, R.G., Shorkey, C.L., and Garcia, E. (1985). "Alcohol Use and Abuse among Mexican Americans." In Freeman, E., ed. *Social Work Practice with Clients Who Have Alcohol Problems*. Springfield, IL: Charles C. Thomas.

McDiarmid, G.W. (1983). "Community and Competence: A Study of an Indigenous Primary Prevention Organization in an Alaskan Village." *White Cloud Journal*, v. 3(1): 53-74.

McDonald, T. (1987). "The Toll on the Black Male." *Sojourners*, v. 16(10): 34-35.

Meinhardt, K. and Vega, W. (1987). "A Method for Estimating Underutilization of Mental Health Services by Ethnic Groups." *Hospital and Community Psychiatry*, v. 38(11): 1186-1190.

Metzger, L.P. (1971). "American Sociology and Black Assimilation: Conflicting Perspectives." *American Journal of Sociology*, v. 76(4): 629-647.

Moore, J. (1973). "Social Constraints on Sociological Knowledge: Academia and Research Concerning Minorities." *Social Problems*, v. 21(1): 65-67.

Munchin, S., Montalvo, B., Guerney, B., Rosman, B., and Schumer, F. (1976). *Families of the Slums*. New York: Basic Books.

Munoz, F.U. (1980). "Pacific Islanders: Life Patterns in a New Land." In Endo, R., Sue, S., and Wagner, N., eds. *Asian Americans: Social and Psychological Perspectives*, Vol. II, p. 153. Palo Alto, CA: Science and Behavior Books.

Munoz, J.A. (1981). "Difficulties of a Hispanic-American Psychotherapist in the Treatment of Hispanic-American Patients." *American Journal of Orthopsychiatry*, v. 51(4): 646-653.

Murase, K. (1977). *Asian American Mental Health from the Community Perspective*. Paper presented at a conference on "Three Perspectives of Asian American Mental Health--The Individual, the Family, the Community."

Nobles, W. (1978). "Toward an Empirical and Theoretical Framework for Defining Black Families." *Journal of Marriage and the Family*, v. 40(4): 679-688.

Nobles, W.W. and Goodard., L. (1984). *Understanding the Black Family: A Guide for Scholarship and Research*. Oakland, CA: Black Family Institute.

Nobles, W.W., Goodard, L., Cavil, W., and George, P. (1987). *African American Families: Issues, Insights, and Directions*. Oakland, CA: Black Family Institute.

Norton, D. (1978). *The Dual Perspective: Inclusion of Ethnic Minority Content in the Social Work Curriculum*. New York: Council on Social Work Education.

Northwest Indian Child Welfare Institute (NWICWI) (1984). *Permanent Planning for Indian Children*. Portland, OR: Parry Center for Children.

Northwest Indian Child Welfare Institute (NWICWI) (1987). *Cross-Cultural Skills in Indian Child Welfare*, Portland, OR: Parry Center for Children.

Nuttall, E.V., Landurand, P.M., and Goldman, P. (1984). "A Critical Look at Testing and Evaluation from a Cross-Cultural Perspective." In Chinn, P.C., ed. *Education of Culturally and Linguistically Different Exceptional Children*, pp. 42-62. Reston, VA: ERIC Clearinghouse on Handicapped and Gifted Children.

Ortiz, A.A. and Maldonado-Colon, E. (1986). "Reducing Inappropriate Referrals of Language Minority Students in Special Education." In Willig, A.C., and Greenberg, H.F., eds. *Bilingualism and Learning Disabilities: Policy and Practice for Teachers and Administrators*, pp. 37-52. New York: American Library Publishing Co.

Owan, T.C. (1982). "Neighborhood-Based Mental Health: An Approach to Overcome Inequities in Mental Health Services Delivery to Racial and Ethnic Minorities." In Biegel, D.E. and Naparstek, A.J., eds. *Community Support Systems and Mental Health: Practice, Policy, and Research*, pp. 282-300. New York: Springer Publishing Co.

Padilla, A.M. and Ruiz, R.A. (1973). *Latino Mental Health: A Review of the Literature*. Rockville, MD: National Institute of Mental Health.

Padilla, A.M., Ruiz, R.A., and Alvarez, R. (1975). "Community Mental Health Services for the Spanish-Speaking/Surnamed Population." *American Psychologist*, v. 30(9): 892-905.

Pedersen, P., Lonner, W.J., and Draguns, J.G., eds. (1976). *Counseling across Cultures*. Honolulu: University of Hawaii Press.

Philips, S.U. (1983). *The Invisible Culture: Communication in Classroom and Community on the Warm Springs Indian Reservation*. New York: Longman.

Polk, S. (1987). "Helping our Children." *Children Today*, v. 16(5): 19-20.

Prince, R.H. (1980). "Variations in Psychotherapeutic Experience." In Triandis, H.C. and Draguns, J.G., eds. *Handbook of Cross-Cultural Psychology. Vol. 6: Psychopathology*. Boston: Allyn and Bacon.

Red Horse, J.G. (1980). "American Indian Elders: Unifiers of Indian Families." *Social Casework*, v. 61(8): 490-493.

Rueda, R. (1984). "Cognitive Development and Learning in Mildly Handicapped Bilingual Children." In Chinn, P.C., ed. *Education of Culturally and Linguistically Different Exceptional Children*, pp.63-76. Reston, VA: ERIC Clearinghouse on Handicapped and Gifted Children.

Ruiz, R.A. and Padilla, A.M. (1981). "Counseling Latinos." In Dana, R.H., ed. *Human Services for Cultural Minorities*. Baltimore: University Park Press.

Ryan, A.S. (1985). "Cultural Factors in Casework with Chinese-Americans." *Social Casework*, v. 66:333-340.

Ryan, R. A. (1980). "A Community Perspective for Mental Health Research." *Social Casework*, v. 61(8):507-511.

Sack, W.H., Beiser, M., Clarke, G., and Redshirt, R. (1985). *The High Achieving Sioux Indian Child: Some Preliminary Findings from the Flower of Two Soils Project*. Paper presented at the Annual meeting of the American Academy of Child Psychiatry.

Sanders, D.S. (1974). "Educating Social Workers for the Role of Effective Change Agents in a Multicultural, Pluralistic Society." *Journal of Education for Social Work*, v. 10(8): 86-91.

Sherover-Marcuse, R. (undated). *Liberation Theory: A Working Framework*. Unpublished manuscript. San Francisco: Unlearning, Racism Workshops, Inc.

Shore, J.H. (1978). "Destruction of Indian Families: Beyond the Best Interests of Indian Children." *White Cloud Journal*, v. 1(2):13-16.

Slaughter, D.T. (1988). "Programs for Racially and Ethnically Diverse American Families: Some Critical Issues." In Weiss, H.B. and Jacobs, F.H., eds. *Evaluating Family Programs*, pp. 461-476. New York: Aldine De Gruyter.

Smith, E. (1981). "Cultural and Historical Perspectives in Counseling Blacks." In Sue, D., ed. *Counseling the Culturally Different*, pp. 141-185. New York: Wiley and Sons.

Solomon, B.B. (1976). *Black Empowerment: Social Work in Oppressed Communities*. New York: Columbia University Press.

Solomon, B. (1981). "Innovations in Service Delivery to Black Clients." In Johnson, A., ed. *The Black Experience: Considerations for Health and Human Services*, pp. 75-94. Davis, CA: International Dialogue Press.

Solomon, P. (1987). "Racial Factors in Mental Health Service Utilization." *Psychosocial Rehabilitation Journal*, v. 11(2): 3-12.

Spurlock, J. (1986). "Development of Self-Concept in Afro-American Children." *Hospital and Community Psychiatry*, v. 37(1): 66-70.

Stehno, S.M. (1982). "Differential Treatment of Minority Children in Service Systems." *Social Work*, v. 27(1): 39-46.

Stroul, B. (1988). *Series on Community-Based Services for Children and Adolescents Who Are Severely Emotionally Disturbed. Home-Based Services, Vol. I.* Washington, DC: Georgetown University Child Development Center.

Stroul, B. and Friedman, R. (1986). *A System of Care for Severely Emotionally Disturbed Children and Youth.* Washington, DC: Georgetown University Child Development Center.

Sue, D.W. (1981). *Counseling the Culturally Different.* New York: Wiley and Sons.

Sue, S. and Morishima, J. (1982). *The Mental Health of Asian Americans*. San Francisco: Jossey Bass.

Taylor, R.L. (1979). "Black Ethnicity and the Persistence of Ethnogenesis." *American Journal of Sociology*, v. 84(6): 1401-1423.

Tolmach, J. (1985). "There Ain't Nobody on My Side: A New Day Treatment Program for Black Urban Youth." *Journal of Clinical Child Psychology*, v.14(3): 214-219.

Tsui, P. and Schultz, G. (1985). "Failure of Rapport." *American Orthopsychiatry*, v. 55(4): 561-569.

VanDenBerg, J. and Minton, B.A. (1987). "Alaska Native youth: A New Approach to Serving Emotionally Disturbed Children and Youth." *Children Today*, v. 16(5): 15-18.

Wilkinson, G.T. (1980). "On Assisting Indian People." *Social Casework*, v. 61(8): 451-454.

Wilson, L. (1982). *The Skills of Ethnic Competence*. Unpublished resource paper. Seattle: University of Washington.

Wright, N., Jr. and Nurse, G. (1981). "Urbanization, Health Care, and Social Change - Some Developmental Implications for the Black Community." In Johnson, A., ed. *The Black Experience: Considerations for Health and Human Services*, pp. 131-146. Davis, CA: International Dialogue Press.

Wright, R., Jr., Saleeby, D., Watts, T., and Lecca, P. (1983). *Transcultural Perspectives in the Human Services*. Springfield, IL: Charles C. Thomas.

Young, T.M. (1987). "Therapeutic Case Advocacy: A Summary." *Focal Point*, v.1(3): 1-5. Published by Research and Training Center, Regional Research Institute for Human Services, Portland State University.

Zane, N., Sue, S., Castro, F.G., and George, W. (1982). "Service System Models for Ethnic Minorities." In Biegel, D.E. and Naparstek, A.J., eds. *Community Support Systems and Mental Health: Practice, Policy, and Research*, pp. 229-257. New York: Springer Publishing Co.

Zollar, A.C. (1985). *A Member of the Family: Strategies for Black Family Continuity*. Chicago: Nelson-Hall.